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House of Representatives

The House met at 12:30 p.m. and was called to order by the Speaker pro tempore [Mr. CLINGER].

DESIGNATION OF SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
October 17, 1995.

I hereby designate the Honorable WILLIAM F. CLINGER, Jr., to act as Speaker pro tempore on this day.

NEWT GINGRICH,
Speaker of the House of Representatives.

MORNING BUSINESS

The SPEAKER pro tempore. Pursuant to the order of the House of May 12, 1995, the Chair will now recognize Members from lists submitted by the majority and minority leaders for morning hour debates. The Chair will alternate recognition between the parties, with each party limited to not to exceed 30 minutes, and each Member, except the majority and minority leader, limited to not to exceed 5 minutes.

JOSEPH ROTBLAT, NOBEL PEACE PRIZE WINNER, CONDEMNS FRENCH NUCLEAR TESTS

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, the gentleman from American Samoa [Mr. FALEOMAVAEGA] is recognized during morning business for 5 minutes.

Mr. FALEOMAVAEGA. Mr. Speaker, on the first day of this month, the Government of France exploded another nuclear bomb in the South Pacific, its second detonation in a new series of tests. France's nuclear bomb—involving a 110 kiloton blast—was seven times more destructive than the bomb that we exploded in Hiroshima 50 years ago.

Mr. Speaker, as we recall the destructive nuclear fury that was first unleashed in history against the people of Hiroshima and Nagasaki, I think it most appropriate to recognize Mr. Joseph Rotblat, a physicist working on the manhattan nuclear bomb project during WW II who quit in protest because of his convictions, and who was personally devastated when he learned of the bomb's consequences in Japan.

Mr. Speaker, I want to congratulate Mr. Rotblat, a Polish-born scientist, who has just been awarded the Nobel Peace Prize by the Norwegian Nobel Committee. Mr. Rotblat, the world's first protester against nuclear weapons, has devoted his entire life to ending the madness of the nuclear arms race. He is the founding member of the Pugwash Conference on Science and World Affairs, as well as the Stockholm International Peace Research Institute, a leading think tank on security and disarmament issues.

Mr. Speaker, at a time France is thumbing its nose at the international community, over 160 nations have officially protested this madness by President Chirac and the Government of France to continued exploding of nuclear bombs in the South Pacific, I find it highly commendable that the Nobel Peace Prize has been awarded to Mr. Rotblat, one of the world's most eminent and vocal opponents of nuclear testing.

Mr. Speaker, Mr. Rotbalt has condemned France's resumption of nuclear testing and has written French President Chirac, urging that France immediately cancel its tests. Mr. Rotblat says, ''There is no reason at all in my opinion for President Chirac to resume tests. I can't see any tactical reason at all. I can only see this as an attempt to make their bomb a little better, or develop perhaps a new type.'' That is right, Mr. Speaker, a bomb a little better. To kill more people.

The two bombs that we exploded in Japan, Mr. Speaker, accounted for over 290,000 men, women, and children who died as a result of those nuclear explosions. What madness, what madness, Mr. Speaker. We can say that let us get rid of chemical and biological warfare, but let us continue dropping nuclear bombs.

Mr. Speaker, again, I commend Mr. Rotblat for his life's work and the Nobel Committee for their selection of Mr. Rotblat as a Nobel recipient. By these actions, the Nobel Committee on behalf of the world community has sent a strong message of protest to the French Government and I would hope that Paris would respond by immediately canceling their nuclear testing in the South Pacific.

What arrogance, Mr. Speaker, that President Chirac has the unmitigated gall to do this. For over 30 years they have been exploding nuclear bombs in the South Pacific. The American people do not know the suffering of the some 100,000 or 200,000 people who live in those islands, and, yes, 28 million people who live in that region. We just have not taken a better understanding of the very real serious problem we have there in the Pacific.

While President Chirac is drinking his sweet wine in Paris, some 200,000 people's lives are at stake if that Muroroa atoll should break and leak, and there are already indications of leakages because of the 168 nuclear bombs that have been exploded on that atoll alone.

What arrogance, Mr. Speaker, what arrogance.

ANTI-BOMB PHYSICIST WINS PEACE PRIZE—NOBEL ''PROTEST'' AGAINST ATOMIC TESTS SHARED WITH ARMS CONTROL GROUP

(By Fred Barbash)

LONDON, October 13.—The Nobel Peace Prize was awarded today to Joseph Rotblat, a British physicist who helped invent atomic weapons in the 1940s, and the organization dedicated to doing away with them that he later formed with Albert Einstein and Bertrand Russell.

This year's prize stands as a ''protest'' against French and Chinese nuclear testing, the chairman of the Norwegian Nobel Committee, Francis Sejersted, said in Oslo as he announced the award to Rotblat and the Pugwash Conferences on Science and World Affairs.

Rotblat, 86, who walked out of the secret U.S. government laboratory at Los Alamos, N.M., in 1944 after deciding the atomic bomb being developed there was unnecessary, also used the occasion to express his ''outrage'' at France's two recent nuclear tests in the South Pacific.

Since 1957, the Pugwash Conferences have been assembling select groups of scientists, including many of the brains behind the American, Russian and British nuclear arsenals, for private exchanges on arms control. They have opened up lines of communication among such scientists, serving as forums for both technical and political issues, and as back channels to top-level policymakers. Subsequently the conferences were broadened beyond the scientific community.

Rotblat said today that the organization's goal is, and always has been, to convince governments that ''the genie can be put back in the bottle.''

A French Foreign Ministry spokesman offered congratulations to Rotblat today, the Reuter news agency reported, but Prime Minister Alain Juppe rejected appeals that France end its nuclear testing program and said the award would have no effect on ''policies we have adopted for reasons of national interest.''

While no single treaty or agreement can be traced precisely to Pugwash discussions, according to historians of the nuclear era as well as Rotblat, the conferences have addressed complex problems—such as anti-ballistic missile systems, test ban monitoring and the spread of chemical and biological weapons—long before they reached the formal negotiating tables of world leaders. They are considered to have exercised at the very least a subtle influence on virtually every major contemporary arms accord.

More broadly, the organization, which has 10 Nobel laureates among its charter members, was among the first of what are now many such groups designed to encourage scientists to confront—and control—the uses of their science.

The group was cited by the Nobel committee for its efforts to ''diminish the part played by nuclear arms in international politics and in the longer run to eliminate such arms.'' It has made scientists ''take responsibility for their inventions,'' it said.

Unlike with last year's Peace Prize—awarded jointly to Israeli leaders Shimon Peres and Yitzhak Rabin and Palestine Liberation Organization leader Yasser Arafat—names of the recipients of this one were not leaked in advance. Indeed, neither Rotblat nor the Pugwash Conferences, of which he is president, was on any of the speculative ''short lists'' published in the Norwegian press.

The Pugwash Conferences, along with philosopher and antiwar activist Bertrand Russell, were viewed with suspicion by some fervent anti-communists during the 1950s and by ardent Cold Warriors afterward. But the organization has been respected for years by arms control professionals. Until today, however, it was relatively unknown to the rest of the world, as was Rotblat, a cheerful, intense man who says he still ''wakes up in a cold sweat'' when he hears about such events as France's nuclear tests.

''Who would expect that a little man like myself and a little-known movement, unknown to the general public,'' would get the Nobel Peace Prize, Rotblat said today as he walked briskly from the organization's grungy office near London's Russell Square to a news conference. ''Who is he?'' bystanders asked reporters as they followed him.

Rotblat, a native of Poland, was working on a one-year atom bomb project at the University of Liverpool in 1939 when the British team of which he was a part joined U.S. scientists working on the Manhattan Project to develop an atomic bomb at Los Alamos.

''I started to work in 1939 on the atom bomb,'' he said in an interview today. ''I was afraid that German scientists would build the weapon and use it to rule the world. I thought that the only way this could be prevented was if we built it too and threatened to retaliate—the classical concept of nuclear deterrence.''

Two new pieces of information gained at Los Alamos persuaded him to leave. First, he said, he learned that a major purpose for the bomb was to threaten the Soviet Union, which was then a World War II ally.

Then, he said, ''at the end of 1944 I learned that the Germans had abandoned their project; the purpose of my being on the project was gone.'' When he informed his superiors at Los Alamos that he was leaving, he said they ''accused me of being a spy'' who was planning to turn over atomic secrets to the Russians. After refuting the accusation, and agreeing for security reasons to a fabricated story about why he was leaving, he was allowed to return to Britain, where he switched from nuclear physics to nuclear medicine.

When he heard that the United States had dropped the bomb on Hiroshima, he said, he was ''devastated. . . . I did not expect it would be used as soon as it was made. I felt angry, worried and fearful about the future of our civilization.''

''The world didn't know it, but we knew that scientists were capable of making a bomb a thousand times more powerful—a hydrogen bomb.''

In 1955, he and Russell decided to seek the help of Einstein in warning the world of the danger they foresaw. From that collaboration came the ''Russell-Einstein Manifesto,'' which declared that ''such weapons threaten the continued existence of mankind.'' Among the signers were 10 men who were or would become Nobel laureates, including Max Born, Percy W. Bridgman, Einstein, Frederic Joliot-Curie, Hermann J. Muller, Linus Pauling, Cecil F. Powell and Rotblat.

From the manifesto emerged the Pugwash Conferences, so named because the first one was financed by American industrialist Cyrus Eaton and held at his retreat in the village of Pugwash, Nova Scotia.

The meetings, which were by invitation only, tended to be small—groups of 25—and moved from country to country.

While participants often read from prepared papers, they could be and were challenged in open give-and-take sessions, according to accounts of meetings by historians.

Invitees have included not only scientists committed to arms control—such as Rotblat—but top-level government scientists guiding the rapid Cold War nuclear arms buildup. Soviet physicists Andrei Sakharov and Igor Tamm and Princeton scientist Frank von Hippel were among the participants.

Rotblat said today he has never been able to say with any precision how much the Pugwash discussions influenced the Soviet position on arms limitations.

At the very least, he said, they opened channels of communication among scientists on both sides of the arms race.

He said he is certain that Pugwash discussions influenced Soviet leader Mikhail Gorbachev's thinking on nuclear issues through the participation of Yevgeny Velikhov, one of the former Soviet leader's key science advisers, who helped persuade Gorbachev not to try to match President Ronald Reagan's Strategic Defense Initiative.

Experts said today that the Pugwash meetings also have contributed significantly to the nuclear testing moratorium observed by the United States and the Soviet Union; to resolving complex issues involving testing verification and monitoring; to the intermediate-range nuclear forces treaty of 1987; and to the nuclear Non-Proliferation Treaty of 1968, designed to stop the spread of nuclear weapons to countries that do not already possess them.

Indeed, the idea for the treaty was first discussed at a Pugwash meeting in 1958, according to the organization's official history.

The peace prize, which will be formally awarded in Oslo in December, carries an award of $1 million. Asked what would be done with the money, Rotblat gestured toward his cramped and cluttered office.

''I haven't really thought about it,'' he said. ''But look around you.''

ROTBLAT, FIRST NUCLEAR PROTESTER, WINS PEACE PRIZE

LONDON, October 13.—Polish-born Joseph Rotblat may have been the world's first protester against nuclear weapons, quitting the Manhattan project to build America's atom bomb in 1945 because of his convictions.

The physicist, who was awarded the 1995 Nobel Peace Prize on Friday, went on to become one of the world's most vocal and effective opponents of the nuclear arms race.

The 86-year-old, who lost his wife in the Holocaust, won the Prize jointly with the Pugwash Conferences on Science and World Affairs, of which he was a founder member and is now chairman.

He is also a founding member of the Stockholm International Peace Research Institute (SIPRI), a leading ''think-tank'' on security and disarmament issues.

Rotblat lives in London where he was professor of physics at the University of London. He has been a British subject since 1946.

He was a refugee from Hitler's Europe who was working at Liverpool University in northern England when World War Two broke out.

He began research on the potential of atomic power in Britain in 1940.

He became a member of a group of British-based scientists who worked on the secret Manhattan Project. But he left the project as Germany headed for defeat, making him possibly the world's first anti-nuclear arms protester.

Rotblat was the only scientist to leave the Manhattan project base at Los Alamos, New Mexico, where the atomic bomb was developed that later devastated Hiroshima and Nagasaki.

His departure was officially said to have been because he wanted to return to Europe to search for his wife.

After the end of World War Two, he founded the Atomic Scientists Association, the forerunner to the Pugwash organisation. He later became president of the organisation, which was dedicated to arms control.

Although Rotblat had always been conscious of the disastrous consequences that

the development of nuclear weapons could entail, he had felt compelled to work on the Manhattan project to develop the atomic bomb before Germany could do so.

When it became clear that Germany had given up working on the atomic bomb, he pulled out of the project and did not know the bomb had been completed until it was dropped on Hiroshima.

He was said to have been ''devastated'' by the consequences of its use on Japan in the dying days of the Pacific war and dedicated his life to campaigning against the nuclear arms race, urging other scientists to do so.

FRANCE UNEASILY CONGRATULATES ROTBLAT ON NOBEL

(By Alistar Doyle)

PARIS, October 13.—France uneasily congratulated ban-the-bomb scientist Joseph Rotblat on winning the Nobel Peace Prize on Friday, dodging the laureate's condemnation of French nuclear tests in the South Pacific.

''We congratulate the Nobel Peace Prize laureate,'' Foreign Ministry spokesman Jacques Rummelhardt told reporters. ''France wants disarmament, including nuclear disarmament, in security.''

''Security will permit disarmament,'' he told the ministry's regular daily press briefing, adding: ''French policy aims to establish security.''

Despite Paris's official congratulations, the award to the veteran nuclear physicist-turned-peace campaigner seemed set to make the French government squirm.

Pierre Lellouche, a member of parliament and former strategic affairs adviser to President Jacques Chirac, said he was ''perfectly scandalised'' and accused the group Rotblat heads of being a former tool of Soviet propaganda.

Both Rotblat and the Norwegian Nobel Committee wasted no time in urging France to cancel nuclear tests. Paris broke a three-year moratorium last month by detonating an underground nuclear device in French Polynesia.

Rotblat, 86, said he hoped the prize ''is a message not only to the French but to the Chinese as well.'' China and France are the only official nuclear powers still testing.

Rotblat wrote to President Jacques Chirac last month protesting against the French tests. ''I think it's very bad,'' he told Reuters in London on Friday.

''There is no reason at all in my opinion for President Chirac to resume tests. I can't see any tactical reason at all. I can only see this as an attempt maybe to make their bomb a little better, or develop perhaps a new type.''

Nobel Committee chairman Francis Sejersted told Reuters Television: ''The specific message to the French is a protest against the nuclear tests, as it is a protest against nuclear tests in general and nuclear armaments in general.''

France has staged two tests since early September despite howls of outrage abroad. Chirac says tests are vital to check France's nuclear arsenal and plans as many as six more before banning testing for ever.

France's La Chaine Info television commented that the impact of the Nobel decision on French diplomacy would hardly have been worse had environmental group Greenpeace won.

Rotblat, who helped develop the first atom bomb in the United States in hopes it would never be used, shared the million-dollar prize with the Pugwash Conferences on Science and World Affairs which he chairs.

Lellouche said: ''I am personally—and as a specialist in these matters—perfectly scandalised by the fact that an organisation which one knows was openly manipulated by the Soviets should be honoured in this way at a time when everyone knows the controversy about the French tests.''

The Pugwash conferences played a back-room role in the Cold War, bringing together scientists, scholars and public figures from East and West to discuss nuclear and other security issues.

AUSTRALIA LAUDS PRIZE FOR ANTI-NUCLEAR CAMPAIGNER

SYDNEY, October 14.—Australia, a fierce opponent of French nuclear testing in the South Pacific, welcomed on Saturday the award of the 1995 Nobel Peace Prize to anti-nuclear campaigner Joseph Rotblat.

A Foreign Ministry spokesman said Australia applauded Rotblat's remark that he hoped the prize would send ''a message not only to the French but to the Chinese as well.''

''We certainly welcome those remarks from someone as eminent as a Nobel Peace Prize winner and it reinforces the wide range of interests against the nuclear testing programmes,'' the spokesman told Reuters.

''It basically reinforces the need for a comprehensive test ban treaty, which Australia has been consistently working towards over so many years.''

Rotblat, a nuclear physicist who devoted his life to trying to ban the bomb he helped create, won the Nobel Peace Prize on Friday and seized the opportunity to spread his anti-nuclear message.

The Norwegian Nobel Committee, which awarded the prize to the 86-year-old peace campaigner and the Pugwash organisation he founded, also made clear it was intended as a protest against French nuclear tests.

France, which is carrying out a series of tests in the South Pacific, and China are the only nuclear powers still carrying out tests.

Australia has said French and Chinese nuclear tests threaten to undermine negotiations for a Comprehensive Test Ban Treaty due for completion next year by encouraging more non-nuclear powers to develop atomic weapons.

Canberra is especially critical of French testing, arguing Paris should, like Beijing, test on their home soil. Having failed to prevent the resumption of tests in French Polynesia, Australia is now trying to embarrass France in world forums.

Australia will seek condemnation of nuclear testing at next month's Commonwealth Heads of Government Meeting in New Zealand.

It is also lobbying with Japan and New Zealand for an anti-testing resolution within the United Nations.

OAS HITS FRENCH TESTS

French nuclear tests are detrimental to peace and international security, the Mexican ambassador to the OAS said as she assumed the rotating presidency of the organization's permanent council.

Ambassador Carmen Moreno de Del Cueto restated the Organization of American States' call for France to end its tests in the South Pacific.

''I deeply regret that the French government has ignored [our] call . . . to suspend the nuclear tests,'' she said. ''I reiterate our call . . . and urge the French government to finally suspend their nuclear tests, which do not contribute to either peace or international security.''

Mrs. Moreno de Del Cueto thanked the OAS for its gradual reforms.

''Little by little the OAS has moved forward in pluralism and tolerance and has begun to eliminate the radical bad habits of the Cold War,'' she said last week.

DO NOT USE SCARE TACTICS

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, the gentleman from Kentucky [Mr. WHITFIELD] is recognized during morning business for 3 minutes.

Mr. WHITFIELD. Mr. Speaker, I have in my hands today an article taken from yesterday's Wall Street Journal entitled ''Clinton Recruits Campaign Team of Nasty Boys.'' I would like to just read the first paragraph:

> Gearing up for 1996, President Clinton is fielding a motley crew of reelection strategists with reputations for shrewdness and ruthless tactics. A mainstay on his team, New Yorker Henry Sheilkoph, readily boasts, ''I subscribe to terror.'' Last year, in speaking to a convention of political consultants, Mr. Sheilkoph told a gathering that terror works in political campaigns because it is so easy to make people hate.

What a sad commentary that is on the political system in America that political strategists would deliberately be trying to terrorize and scare people in America, and the efforts to terrorize have already started in the area of Medicare.

As you know Medicare will be bankrupt by the year 2002, according to the President's own board of trustees, and we are committed to preserving that plan, to make it a better plan than it is today. Under the Republican plan, we are going to be spending $355 billion more over the next 6 years, 7 years, on Medicare than were spent in the past 7 years.

But more important than that, if you work in a major corporation today or if you work in the Federal Government today, or if you are in the U.S. Congress today, you have options to choose your health care from five or six different plans. But if you are a senior citizen in America today, you have one option, a fee-for-service option.

Some suburban areas and urban areas, you have an HMO that you can participate in. But we are going to provide senior citizens with additional options. If they want to keep the system they have today, they can do so. If they want to go to an HMO, they can do so. If they want to go to provider service networks, they can do so. If they want to be into a medical savings account, paid for by the Government, they can do so.

So I would urge the President, I would urge those Members of the Democratic Party who are trying to use this issue to scare the American people, to come forward and be honest and say, ''Yes, this is going to be a better system.''

We do not need nasty boys, so to speak, running political campaigns in America.

MEDICARE FRAUD AND ABUSE

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, the gentlewoman from Connecticut [Ms. DELAURO] is recognized during morning business for 5 minutes.

Ms. DELAURO. Mr. Speaker, this week the House of Representatives will take up unprecedented cuts of $270 billion from Medicare which has been a lifeline for over 37 million seniors. During its 30 year legacy, Medicare has provided our elders with the security of health care coverage and has lifted millions of our seniors out of poverty. Medicare is a solemn contract between this Nation and our elders. It should not be tampered with lightly.

Over the years, those of us genuinely concerned with strengthening the Medicare system have urged a crackdown on Medicare fraud. The Congressional Budget Office estimates that stopping the growing problem of fraud will reap billions of dollars in savings.

But you don't need some policy-wonk's study to tell you that the system is rampant with waste, fraud, and abuse. Just visit one of our Nation's senior centers and sit down for a senior lunch and ask one of our senior citizens to show you their bills.

However, the Republican bill we will take up later this week does not toughen enforcement. It does not even defend the status quo. Even worse, the Republicans turn back the clock on cracking down on Medicare fraud.

Sadly, I am not surprised. As Speaker GINGRICH said last week in this Washington Times article, in his feeble effort to defend GOP moves to reduce penalties and enforcement efforts against Medicare fraud: ''murderers out after 3 years'' and rapists who don't even get tried.'' ''For the moment, I'd rather lock up the murderers, the rapists and the drug dealers,'' he said. ''Once we start getting some vacant jail space, I'd be glad to look at it.''

The Republican leadership is not interested in correcting and punishing the criminal elements in the Medicare system. Because that may hurt the special interest supporters in the medical industry.

Their priority is to ensure that the special interest supporters in the medical industry are taken care of, with minimal losses in this debate on cutting Medicare.

So, while the Speaker cuts a deal in a backroom with the American Medical Association to make sure that the interests of doctors are protected, while the health care cheats make a fast buck at the government's expense, seniors are being asked to pay more in out-of-pocket costs and deductibles.

My colleagues on the other side of the aisle have abandoned the most obvious of the potential savings in the Medicare program: Combating Medicare fraud and abuse. I introduced legislation this Congress, the Health Care Prosecution Act, to do just that. My bill stops health care cheats in their tracks, retrieves the financial losses in restitution and fines, and puts the criminals behind bars so that they are unable to promulgate more health care scams in the future.

Further, my legislation establishes a temporary health care fraud and abuse commission to study the nature, and extent of fraud in our system. The commission would make recommendations to Congress on innovative approaches to attack fraud.

Mr. Speaker, I think my bill is a good one but it is not the only effective way to crack down on fraud. There are lots of good ideas out there about how to rid our system of the scams that are ripping off our Nation's seniors and taxpayers.

I am sorry that my Republican colleagues have chosen to pursue none of them.

THE GOAL OF THE MEDICARE PRESERVATION ACT

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, the gentleman from Ohio [Mr. HOKE] is recognized during morning business for 5 minutes.

Mr. HOKE. Mr. Speaker, on April 3, 1995, the Medicare trustees, which include three members of the President's Cabinet, issued the following warning: ''Medicare begins going bankrupt next year, and unless prompt and decisive action is taken, Medicare will be completely out of money by 2002.''

There is no reason to doubt the accuracy of the report or its conclusion, and I urge every American to obtain an official summary of the report from their Congressman's or Congresswoman's office to judge for themselves. They can get that by calling 202–225–3121, that is, 202–225–3121. Ask for an official 14 page summary of the Medicare trustees' report.

This week, the House of Representatives will take a giant step forward toward putting Medicare back on sound fiscal footing and giving our seniors the same choices enjoyed by Federal employees, including Members of Congress and all citizens in the private sector when it passes the Medicare Preservation Act of 1995.

The goal of the Medicare Preservation Act is to preserve Medicare for current beneficiaries, protect future beneficiaries, and strengthen it through reforms that have been tested and proven in the private sector. The bottom line is that if Medicare is not reformed, either seniors will be forced to accept sharply curtailed medical services or working Americans will be forced to pay increased payroll taxes estimated by the Heritage Foundation to cost my constituents in northeastern Ohio an average of an additional $1,200 per year.

Under the Medicare Preservation Act, total Medicare spending will increase, will increase, will increase, will increase 54 percent from $161 billion in 1995 to $274 billion in 2002.

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On an annual per beneficiary basis, average spending will increase, that was increase, from $4,800 today to more than $6,700 in 2002. Obviously not only is Medicare not being cut, but at an average increase of about 6.5 percent per year it will grow faster than the current 2.3 percent of private sector medical inflation and more than fast enough to accommodate all new entrants into the system. Only in the bizarre and convoluted world of Washington bookkeeping and partisan bickering can such an indisputable spending increase be called a cut.

The Medicare Preservation Act will give seniors the same four choices that all Federal employees, including Members of Congress, have. First, if they want to, seniors can stay with the current Medicare system exactly as it is today, and, if they choose another option and decide later they want to return to traditional Medicare, they can do that, too. No senior citizen will be forced to give up his or her current Medicare coverage, switch doctors, or be forced into a plan that they do not want.

Second, seniors can opt for managed care and join a health maintenance organization, or HMO, in which beneficiaries agree to receive their medical care from a defined pool of providers in exchange for lower out-of-pocket expenses and broader coverage, which might include prescription drugs, dental care, and eye wear. Many seniors, particularly those those private physicians are already associated with the HMO that they choose, will find this to be an attractive alternative.

Third, seniors can opt for a medical savings account plan which uses the beneficiary's Medicare stipend to fund both catastrophic health insurance plus an MSA, a medical savings account, out of which seniors would pay for routine medical needs. Seniors choosing this plan would have complete control over the money they spend on medical care, and any money left over in the medical savings account at the end of the year would belong to the senior, not to the insurance company nor to the Government. Seniors can join provider service networks similar to HMO's organized by doctors and hospitals themselves.

The Medicare Preservation Act will also aggressively attack waste, fraud, and abuse that has contributed so much to Medicare's rising costs. Incredibly, the Congressional Budget Office has estimated that as much as 20 percent of Medicare spending is fraudulent. The Medicare Preservation Act requires the Department of Health and Human Services to identify and eliminate these huge losses, including financially rewarding Medicare recipients who report abuses. It makes doctors and hospitals accountable for their actions, and imposes stiff new penalties on anyone caught defrauding Medicare.

Another important point is that the portion of Medicare part B costs paid by seniors through premiums, currently 31.5 percent, will not change. Over the past 7 years, part B premiums have nearly doubled, rising from $24.80 in 1988 to $46.10 today.

Mr. Speaker, that is the plan. It is innovative, responsible, and cost effective, and we are going to pass it on Thursday.

SAVING MEDICARE

The SPEAKER pro tempore (Mr. CLINGER). Under the Speaker's announced policy of May 12, 1995, the gentleman from New Jersey [Mr. PALLONE] is recognized during morning business for 5 minutes.

Mr. PALLONE. Mr. Speaker, I would also like to use my time to talk about Medicare. As we know, the Republican leadership plans to bring up their cuts in Medicare and their program that in my opinion will destroy the Medicare system in the bill this Thursday, without really any significant debate that has occurred so far.

I think there are many aspects of this Republican Medicare plan that disturb me greatly, but the one thing I think that has not been stressed enough is how this is going to have such a negative impact on the quality of health care in the United States.

There was an article last Friday in the New York Times, an op-ed by Mr. Melvin Connor out of Atlanta. He says essentially what these changes in Medicare as well as Medicaid are going to do is to create a third-world atmosphere, essentially, for health care in the United States. He calls it ''Medicare and the Third Worldization of America.''

The reason he says this essentially is because when you take so much money out of the health care system, out of Medicare and out of Medicaid—and we are talking about $450 billion—the inevitable result is that the system is squeezed so much that the quality of health care suffers.

Few people I think realize this. Many of us realize that our country has the best health care system in the world. It is not always evenly distributed. A lot of the poor people or the poor elderly oftentimes do not have the best quality care or access to that best quality care. But the bottom line is that the system as a whole works fairly well right now, and we do have the best quality care in the world.

But what this proposal does, what the Republican proposal does, is to basically cap the Medicare Program and limit Medicare spending to specific dollar amounts in the law. These caps—and not the choice that the Republicans talk about, which is not going to be there—these caps on Medicare spending essentially yield the enormous Medicare budget savings that the Republicans keep talking about.

But the problem is that the caps on spending bear no relationship whatsoever to the costs of health care. Instead, they were set up to produce the budget savings Republicans need to pay for their tax cut for the wealthy. When inflation and enrollment growth push Medicare costs beyond these arbitrary budget caps, Medicare and the elderly and disabled citizens that are part of the program will be at serious risk.

Now, one of the previous speakers this morning talked about the trustees and said well, we have to do something to Medicare; otherwise it is going to go broke.

That simply is not true. If you look at the trustees report that comes out this year that estimates that the program has another 7 years, every year over the last 25 or 30 years the trustees have come out with a report. Sometimes they have predicted insolvency in 2 years, sometimes in 7, sometimes in 10.

The bottom line is that the trustees are not saying that this kind of a cut, that this magnitude of a cut in the Medicare Program, is what is necessary in order to keep Medicare solvent. In fact, in a letter that I previously quoted from Robert Rubin, the Secretary of the Treasury, dated September 21, to the Speaker, to Speaker GINGRICH, he simply said:

> No Member of Congress should vote for $270 billion in Medicare cuts believing that reductions of this size have been recommended by the Medicare trustees or that such reductions are needed now to prevent an imminent funding crisis. That would be factually incorrect.

In fact, the trustees have not said that. The trustees have said that something like $90 billion in savings would do fine in order to keep the Medicare Program solvent well beyond the next 7 years.

What we are talking about here is an effort to basically squeeze all this money out of the Medicare Program and provide us essentially with a third world health care system just in order to achieve a tax cut for the wealthy. If anybody doubts that, I would suggest to them that they look at what came out of the House Committee on Commerce, which is the committee that I serve on in Congress. We tried in the Committee on Commerce when we were marking up the Medicare bill last week to make the point that if you really felt that these cuts were not being achieved in order to give a tax break for the wealthy, then why not take the Medicare Program out of this budget reconciliation bill that we are considering in Congress right now?

In other words, if the Republicans really believe that they are trying to save Medicare, rather than take this money that they are cutting and using it for a tax cut for the wealthy, then why do they need to deal with Medicare in the context of the budget? Why do they not give us some time, a couple weeks, a couple months, to look at the Medicare Program, to look at all its different aspects, and try to deal with it in a way that tries to come up with a better quality health care system, not a worse one?

The answer is very simple. They were not willing to do that. We actually submitted an amendment in the Committee on Commerce to take the bill out of the reconciliation, and it failed along a partisan vote line because the Republicans are not serious. They want to use the money for the tax cut.

THE RAPID GROWTH IN TRAVEL AND TOURISM

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, the gentleman from Wisconsin [Mr. ROTH] is recognized during morning business for 5 minutes.

Mr. ROTH. Mr. Speaker, America needs a bold agenda for change, change not only in the way we do business, but in a new way at looking at the world. Consider for a moment that the single largest global revenue producer for individuals and governments, travel and tourism, has been almost totally ignored. Yet, like a sleeping giant, travel and tourism is awakening from its slumber, and everyone, particularly the politicians, will have to stand and take notice.

This year, travel and tourism is finally getting a little of the recognition it deserves, and justly so. Travel and tourism employs some 204 million worldwide, almost as many people as we have living in the United States minus California. That equals 10 percent of the global work force.

Tourism produces $655 billion in tax revenue. More than 10 percent of all capital investment worldwide goes into travel and tourism. Maybe that is why travel and tourism is growing 23 percent faster than the world economy.

But the most revealing statistic, the one that should make all of us collectively hang a welcome sign on every port of entry into the United States, is that there is an increase of some 50 million travelers, an increase of some 50 million travelers worldwide in the next 5 years. This could mean tens of thousands of new jobs for American workers, but only if we in Congress have the foresight to take advantage of this remarkable opportunity.

Yet when it comes to travel and tourism, we in Congress have been more than willing to take a back seat to any other country in the world, any country, that is willing to put priority in job creation. We in Congress have been oblivious to the dynamics of travel and tourism, the tremendous force in this industry, the tremendous force it has on our economy. We are all too often engrossed in issues of the day and fail to take a look at the big picture.

That is why as chairman of the 297-member Travel and Tourism Caucus, the largest caucus in Congress, I ask all Members to focus on the juggernaut of this global economy.

Also, on a personal note for each Member, let me repeat a fact that you are all acquainted with. Travel and tourism is either the first, second, or third largest employer in your congressional district. These are the businesses, the working men and women in your district. Think of them when you think of travel and tourism. Virtually all over the world, and particularly in

the United States, travel and tourism is the predominant industry for jobs that our people need. But note well, the United States is losing its market share in travel and tourism, and this means that we are losing jobs and tax revenue.

Effectively ignored all too often by Congress for its economic benefits, travel and tourism has had a rough row to hoe, a road full of tax pitfalls, disincentives and economic roadblocks, and American workers, small businesses and local economies, especially in our small towns, have suffered.

What should we do? I will start by telling you what I am not willing to do. I am not willing to see thousands of new jobs created in other countries and sit back wondering why it did not happen here in the United States. I am not willing to see Main Street, America fade away and then wonder was there something I could have done or other Members of Congress could have done.

On October 30 and 31 of this year, in a few days, we will hold the first ever White House Conference on Travel and Tourism. We are going to strategize on a national tourism plan that will create jobs here in America, keep Main Street alive, and pump new tourism dollars into our local economies.

As a member of the Travel and Tourism Caucus, this is your conference, too. Come, take part, and get in step with the American working people. One out of every nine workers is employed by travel and tourism. Just think of the tremendous impact this industry has on your congressional district.

For us the travel and tourism industry is the No. 1 source of foreign revenue. Fifty-six billion dollars came into the United States last year because of foreign tourists, $56 billion that we did not have to get from our taxpayers here in this country. Travel and tourism has moved to the forefront of our national economy. It cannot be ignored, and justly so.

Mr. Speaker, if the Members have not already done so, I invite them as Members of Congress to join the 297 members of the Travel and Tourism Caucus. Join us on October 30 and 31 at the White House conference and get involved in this blockbuster industry of the 1990's and the 21st century.

Let me predict that as we move into the new century, travel and tourism will be No. 1 in jobs, No. 1 in revenue, No. 1 in economic activity, and I invite you all to join the Travel and Tourism Caucus today.

MORE COMPREHENSIVE DEBATE NEEDED ON MEDICARE PLAN

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, the gentleman from Illinois [Mr. DURBIN] is recognized during morning business for 5 minutes.

Mr. DURBIN. Mr. Speaker, if the Gingrich Republican plan to cut $270 billion out of Medicare is such a good idea, why were there no committee hearings to speak of? Why was this bill not brought to the floor so Members could have an opportunity to amend it and debate it at length?

In fact, this week on the floor of the House of Representatives in Washington, DC, we will consider this $270 billion cut in Medicare, the biggest cut in the history of this program, with only a handful of days of hearings in various committees, and a very limited opportunity for debate. It is no surprise that over the weekend, if you read the New York Times, you find that more things are starting to trickle out in terms of what is included in this Medicare change.

□ 1300

Some of the changes that are being proposed are absolutely horrible. One of the worst relates to the fraud and abuse of the Medicare system. Most of the people that we talk to, who are on Medicare, believe the system needs to be changed and improved. I certainly do.

One of the first places they suggest that we turn to is to stop overbilling, stop the overcharging of the Government for medical services. We know that the vast majority of health care providers under Medicare are honest, ethical people. The doctors, the hospital administrators, those who provide various medical equipment and medical supplies are by and large very honest people, but 1 or 2 percent of them are not and they cost us as taxpayers dearly.

The General Accounting Office estimates that about 10 percent of all the billing to Medicare each year is fraudulent, to the tune of about $18 billion a year, more than enough to make Medicare a sound system for years to come. Unfortunately, if we look closely at what Mr. GINGRICH has proposed under his Medicare reform, we find instead of tightening it up to eliminate the fraud and to eliminate the abuse, the gentleman takes a step in the opposite direction. He lifts the burden now put on Medicare providers so that they cannot be guilty of self-referral.

What is self-referral? OK. A senior goes to the doctor, the doctors takes a look at the person and says, ''I think you need a test.'' Now, how many of us would argue with a doctor at that point? ''If I need a test, Doctor, and you think it is right, let us do it.'' But we found out something curious. If the doctor owns the laboratory that performs the test, the inspector general's office finds out that 45 percent more tests are ordered.

The doctor is not only making money out of the examination, the doctor is making money out of the test. In fact, they are overtesting the patients, beyond what they need for good health care. We put in some regulations and said let us put an end to it. If a patient needs it, if a patient needs a test, let us do it, but this sort of self-referral so that some doctors who own the labs can make more money is a rip-off.

Well, guess what? Along comes the Gingrich Medicare proposal and the whole question of self-referral is pushed to the back.

Then there is a question of kickbacks. We honestly found in the last 2 years dramatic instances of kickbacks, where one group of physicians was referring to another group of physicians, when it was totally unnecessary, and the second group of physicians would kick back some money to the first group for the referral. In one instance, one group paid over $300 million in fines for these kickbacks under Medicare. In the second instance, over $150 million in fines.

So what does the Gingrich Medicare bill do about this? Sad to say, it makes it easier for this kind of kickback to take place. It reduces the likelihood that any medical provider is going to be found of any kind of criminal penalty as a result of this kind of waste and abuse.

Mr. Speaker, there should be things Democrats and Republicans agree on in this town when it comes to Medicare. The first and foremost of these should be that the seniors should not be ripped off, they should not pay more out-of-pocket for medical care than they ought to, but, more importantly is, taxpayers should not be ripped off.

Why in the world at a time when we are facing these deficits should we allow this Medicare system to become so lax and so flabby that, in fact, it is overcharging taxpayers to the tune of more than $18 billion a year? So along come my Republican friends, having sat down and struck a deal with the doctors of America, the AMA, and they are going to relax the standards when it comes to waste and fraud. That is not fair. I do not think anybody in this country believes that is fair. It may be a sweetheart deal, but it is one that should see the light of day.

Mr. Speaker, it should trouble everybody listening to this that the fact is we are going to consider the most significant change in Medicare this week by the Gingrich Republicans without the light of day, without an opportunity to bring these proposals before the public. We will hear about them, but I hope we hear about them before it is too late.

SUPPORT THE MEDICARE PRESERVATION ACT

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, the gentleman from Maryland [Mr. BARTLETT] is recognized during morning business for 5 minutes.

Mr. BARTLETT of Maryland. Mr. Speaker, this week, this Thursday, the House of Representatives will vote on a plan that will save and preserve the Medicare program for the current generation of senior citizens by introducing choice and competition into this 30-year-old health insurance program for the elderly and disabled.

Let me start by reviewing why these changes are necessary. Then I want to talk about some of these changes.

The trustees of Medicare, four of them appointed by President Clinton, three of them Cabinet Secretaries, warned America in their April annual report that the Medicare part A trust fund that pays hospital bills will go bankrupt by 2002.

Beginning next year, in 1996, for the first time in the history of Medicare, more money will be spent on senior's hospital bills then will come into the trust fund from the payroll taxes that are paid out of the wages of current workers.

If we do nothing, seniors' out-of-pocket costs would continue to climb and Medicare would be bankrupt in 7 years.

If we do nothing and Medicare goes bankrupt, the Government does not have the authority to pay for the hospital bills of any one senior, let alone the 37 million who now depend on it, and the millions more who will need it in the future.

Clearly doing nothing was not a responsible or acceptable option. The problem will not go away—it will only get worse.

Republicans stepped up to the challenge of saving Medicare because Medicare is a vital program that is too important for politics as usual. That is why we began in the spring and have continued throughout year to hold hearings here in Washington. In fact, between the House and the Senate there have been 50 hearings.

More importantly, we have held meetings back at home with seniors, doctors, nurses, hospital administrators, insurance companies, advocacy groups such as the American Association of Retired Persons—AARP.

Based on what the people in western Maryland told me and what other members learned from their constituents, we developed the Medicare Preservation Act.

The Medicare Preservation Act is based on two simple, but effective principles: First, choice for seniors, and second, competition among health care providers.

Choice and competition always do two things in our free enterprise system: Lower costs, and improve quality. That is what the Medicare Preservation Act is about. That is what the Medicare Preservation Act will do. It will give seniors the right to choose the health care and health care insurance plan that best meets their needs, not the Government's. It will give seniors the choice between traditional Medicare or new options.

If seniors do nothing, they will keep traditional Medicare. It will preserve seniors' right to keep their current doctor and hospital. I have two special concerns that the Medicare Preservation Act solves.

Rural areas of America, such as western Maryland, will greatly benefit from the new option of provider service networks—or PSN's. Provider service networks are collaborative partnerships between hospitals and doctors that will compete against insurance companies. Provider service networks already exist in western Maryland, but they are hampered by unbelievable amounts of redtape.

The unnecessary redtape is eliminated under the Medicare Preservation Act so that doctors and hospitals can concentrate on what they want to do and should do—take care of patients. That is why the Maryland State Medical Society supports the Medicare Preservation Act.

Seniors know that fraud is a big problem in Medicare. The GAO estimates 10 percent or so. The Heritage Foundation estimates up to 20 percent of Medicare costs—that is up to $32 billion is estimated to be lost to waste, fraud or abuse each year.

For instance, Mr. Charles Hardy of Cumberland, MD, found that Medicare was billed for services for his mother—after she died. The Medicare Preservation Act attacks waste, fraud, and abuse in two ways.

First, it sets up a rebate program that will award people like Mr. Hardy with 10 percent of savings over $1,000. Mr. Hardy got no reward for being diligent. People like Mr. Hardy deserve a reward for taking the time and trouble to look for and report mistakes they find in Medicare bills. Health care providers need to be aware that people like Mr. Hardy are paying attention.

Second, the new options for seniors that will be created by the Medicare Preservation Act means that doctors and hospitals, health management organizations, insurance companies, and provider service networks will have to compete for senior's business based on quality and price.

The Medicare Preservation Act is a real, honest, practical, long term, solution that will save Medicare because it is based upon the two key advantages that we seniors have.

We are smart because of the accumulated wisdom of our experience.

We have the time to pick the plan that is right for us.

I urge all of my colleagues to join me in supporting the Medicare Preservation Act.

SUPPRESSION OF POLITICAL ADVOCACY AND FREE SPEECH

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, the gentleman from Colorado [Mr. SKAGGS] is recognized during morning business for 5 minutes.

Mr. SKAGGS. Mr. Speaker, I would like to address for just a few minutes a proposal that is pending in the House that is generally referred to as the Istook amendment or the Istook-McIntosh proposal. What, one may ask, is that about? Well, this is an effort to set up a very, very complicated system for regulating, if one can believe this, regulating and really suppressing political speech and political advocacy in this democracy, which is based, of course, on freedom of political speech and association.

There are many, many aspects to this proposal, but it is often masqueraded, anyway, under the guise of ending welfare for lobbyists. And that may sound like a catchy and compelling concept until we realize who it is that we are talking about. This proposal is intended to get at such organizations as the American Red Cross, the United Church of Christ, the YMCA, the Girl Scouts, a whole range of mainstream American charitable and philanthropic organizations that happen, in addition to their regular activities in our communities, to be involved in some fashion or other in the debate and consideration in America of good public policy.

Many of these organizations, as are well known, are involved in a whole range of philanthropic and charitable activities in their communities in their States. They learn about the problems in our society from those activities, and, understandably, they exercise their first amendment rights to communicate those concerns to State and local and Federal policymakers and legislators. This proposal would put limits on what they can do to help us in the Congress or in the State capitals do a better job.

Why? Well, I cannot really answer that question. The proponents of this proposal seem to think that we should go back to a kind of 19th century view of charity, in which the only thing that is legitimate is to feed the poor, house the homeless, do the fundamental good works, which are clearly very, very important. But if they learn something from that, that might help inform Government to do its job better, well, that is out of line.

Mr. Speaker, this reminds me of our colleague from Georgia, Mr. GINGRICH's, comments about wanting to go back to a kind of 19th century orphanage way of dealing with children who do not have the advantages of having both parents at home.

Now, this is being called, this effort to get at the political activities of nonprofits and, for that matter, individuals and businesses that happen to be involved in the political life of this country, going after one of Washington's dirty little secrets; that is that somehow the idea that the YMCA or the Girl Scouts or the American Red Cross might be involved in political advocacy is an anathema.

Mr. Speaker, I think it may also have something to do with wanting to divert attention from one of the real dirty little secrets in town right now, which is the avoidance of dealing with real lobbying reform and real gift reform around this place. We are preoccupied in this proposal, again with, I think, a real diversionary tactic.

When I am home, I at least do not have a lot of people coming up to me saying, ''Congressman, I wish you

would rein in the Girl Scouts from being quite so active politically. It is just an outrage.'' Or commenting about how dangerous it is to American society to have the YMCA involved in the debate about child care.

□ 1315

But while we are off on this tangent, people are being distracted from the fundamental inaction in the House of Representatives on real, central, political reform here in the House; namely, getting to the activities of real lobbyists and their inappropriate ways of trying to influence decisions here through a whole range of extracurricular activities, whether it is gifts or meals or junkets or what have you.

Mr. Speaker, why haven't we taken up that legislation which most Members of the House arrived in January saying ought to be central to our reform agenda around here? Why are we not doing that, rather than messing around with this very, very trivializing and, I think, insulting diversion about wanting to make sure that the Girl Scouts do not have too much say in the political life of this country.

RECESS

The SPEAKER pro tempore (Mr. CLINGER). There being no further requests for morning business, pursuant to clause 12, rule I, the House will stand in recess until 2 p.m.

Accordingly (at 1 o'clock and 15 minutes p.m.), the House stood in recess until 2 p.m.

□ 1400

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. RIGGS) at 2 p.m.

PRAYER

The Chaplain, Rev. James David Ford, D.D., offered the following prayer:

We pray, gracious God, for a clear vision of ourselves and of the world in which we live and work and have our being. Enable us to see ourselves as we truly are—created in Your image and marked by opportunities to be the people You would have us be—and also aware that we often miss the mark and lose the vision. We know, O God, that if we do not see the heavenly vision and miss the direction for our lives, our steps will wander and we will lose our way. Open our eyes, gracious God, so we see the path to freedom and opportunity and of service to others. This is our earnest prayer. Amen.

JOURNAL

The SPEAKER pro tempore. The Chair has examined the Journal of the last day's proceedings and announced to the House his approval thereof.

Pursuant to clause 1 of rule I, the Journal stands approved.

Mr. LINDER. Mr. Speaker, pursuant to clause 1, rule I, I demand a vote on agreeing to the Speaker's approval of the Journal.

The SPEAKER pro tempore. The question is on the Chair's approval of the Journal.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. LINDER. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Pursuant to clause 5, rule I, further proceedings on this question are postponed.

The point of no quorum is considered withdrawn.

PLEDGE OF ALLEGIANCE

The SPEAKER pro tempore. The gentleman from Ohio [Mr. TRAFICANT] will lead the House in the Pledge of Allegiance.

Mr. TRAFICANT led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Lundregan, one of its clerks, announced that the Senate had passed with an amendment a bill of the House of the following title:

H.R. 2076. An act making appropriations for the Departments of Commerce, Justice, and State, the Judiciary, and related agencies for the fiscal year ending September 30, 1996, and for other purposes.

The message also announced that the Senate insists upon its amendment to the bill (H.R. 2076) ''An Act making appropriations for the Departments of Commerce, Justice, and State, the Judiciary, and related agencies for the fiscal year ending September 30, 1996, and for other purposes'', requests a conference with the House on the disagreeing votes of the two Houses thereon, and appoints Mr. GREGG, Mr. HATFIELD, Mr. STEVENS, Mr. DOMENICI, Mr. MCCONNELL, Mr. JEFFORDS, Mr. COCHRAN, Mr. HOLLINGS, Mr. BYRD, Mr. INOUYE, Mr. BUMPERS, Mr. LAUTENBERG, and Mr. KERREY to be the conferees on the part of the Senate.

The message also announced that the Senate had passed a bill of the following title, in which the concurrence of the House is requested:

S. 1267. An act to amend the Congressional Award Act to revise and extend authorities for the Congressional Award Board.

The message also announced that the Senate disagrees to the amendments of the House to the bill (S. 641) ''An Act to reauthorize the Ryan White CARE Act of 1990, and for other purposes'', requests a conference with the House on the disagreeing votes of the two Houses thereon, and appoints Mrs. KASSEBAUM, Mr. JEFFORDS, Mr. FRIST, Mr. KENNEDY, and Mr. DODD, to be the conferees on the part of the Senate.

The message also announced that the Senate disagrees to the amendments of the House to the bill (S. 652) ''An Act to provide for a pro-competitive, deregulatory national policy framework designed to accelerate rapidly private sector deployment of advanced telecommunications and information technologies and services to all Americans by opening all telecommunications markets to competition, and for other purposes'', agrees to a conference asked by the House on the disagreeing votes of the two Houses thereon, and appoints Mr. PRESSLER, Mr. STEVENS, Mr. MCCAIN, Mr. BURNS, Mr. GORTON, Mr. LOTT, Mr. HOLLINGS, Mr. INOUYE, Mr. FORD, Mr. EXON, and Mr. ROCKEFELLER, to be the conferees on the part of the Senate.

APPOINTMENT OF CONFEREE IN LIEU OF CONFEREE ON S. 395, ALASKA POWER ADMINISTRATION ASSET SALE AND TERMINATION ACT

The SPEAKER pro tempore. The Chair appoints, without objection, Mr. OBERSTAR as a conferee for consideration of House amendment No. 4 for the conference on the bill S. 395 to fill the vacancy resulting from the resignation from the House of the gentleman from California, Mr. Mineta.

There was no objection.

The SPEAKER pro tempore. The Clerk will notify the Senate of the change in conferees.

ACT NOW TO PRESERVE MEDICARE

(Mr. LINDER asked and was given permission to address the House for 1 minute.)

Mr. LINDER. Mr. Speaker, Medicare is a lot like a 1965 model car. It is comfortable transportation, but it may not always be reliable. The 1965 model lacks the efficiency of the newer cars and is expensive to maintain.

The Medicare Preservation Act would allow folks to have the health care equivalent of a new car with air-conditioning, better gas mileage, or other options of their choice. The technology has improved and the new safety features are important. Of course, those who prefer the classic car are welcome to keep it.

I urge the American people and particularly our senior citizens to be informed consumers. Do not be hastily swayed by the advertising of AARP and other groups which depend on Government spending and bureaucracy for their livelihoods.

When individuals in my district in Georgia understand the facts of the Medicare crisis they soon realize that the Medicare Preservation Act is the best solution. They know we must act

now to save Medicare for today's retirees and preserve it for the next generation.

SPECIAL INTERESTS WINNING IN REPUBLICAN MEDICARE PROPOSAL

(Ms. DELAURO asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. DELAURO. Mr. Speaker, last week, we learned the extent to which the special interests are winning out over the public interests when it comes to the Republican Medicare proposal. Two groups came to Washington to protest the GOP plan to cut $270 billion from Medicare; one group got a $3 billion deal, the other got arrested.

Here is a photo, of 67-year-old Roberta Saxton as she is handcuffed by Capitol Police. Her crime? She came to the people's House to ask questions about plans to change her health care plan.

While Roberta was being arrested, the American Medical Association was treated to a different reception. They did not get handcuffed, they got handed a $3 billion deal in a private meeting with Speaker GINGRICH. As the New York Times editorialized this weekend in a piece entitled ''Bribes for the Doctors''—the Speaker's concessions made an already bad Medicare bill substantially worse. This bill was never designed to give the elderly high quality health care. It is less likely to do so now.

MEDICARE PRESERVATION ACT WILL PRESERVE, PROTECT, AND STRENGTHEN MEDICARE

(Mr. JONES asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. JONES. Mr. Speaker, the Republican Party has boldly led the 104th Congress in the effort to save Medicare. However, these efforts are being challenged by Washington-based special interest groups who are receiving tax dollars.

The AFL–CIO has received $1.3 million in Federal grants but has spent $1.4 million attacking Medicare. The AARP has received $24 million and the National Council of Senior Citizens received $71 million. The American taxpayers should not be forced to fund lobbyists who intentionally mislead our elderly.

The Medicare Preservation Act will preserve Medicare for future generations, protect the program so that Medicare will stay as the beneficiaries know it to be, and strengthen it to provide coverage options, that empower citizens to choose the health plan that fits their needs.

Instead of helping save Medicare, these special interest groups are trying to hold back the progress that must be made.

IN MEMORY OF MEREDITH MILLER

(Mr. GIBBONS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. GIBBONS. Mr. Speaker, we pause here today for just a moment to remember Meredith Miller.

Meredith Miller was murdered a year ago today as she was returning from studying to her residence in Virginia.

Meredith Miller was one of those wonderful kinds of persons. She was a very bright student, a wonderful giver. She gave of herself to many wonderful causes, and she was preparing to lead a really spectacular life.

Her murder was unusually brutal. It was a terrible loss of a wonderful life and a terrible loss to her mother and father and her brother and her kin and family and friends who reside in my congressional district.

We all loved Meredith Miller. She was the kind of person we want our daughters to be. She was the kind of American we want our fellow citizens to be.

Justice was done. The murderers were captured. The murderers were tried and sentenced, and they are now serving time in jail. But nothing can return to Meredith Miller her life or to her family their wonderful daughter and sister.

All murder is useless, but Meredith Miller's murder was useless, tragic, and a horrible crime.

Let us pause and remember Meredith Miller.

MEREDITH MILLER WILL ALWAYS BE REMEMBERED

(Mr. BUNN of Oregon asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BUNN of Oregon. Mr. Speaker, before we start today's business, I would like all of my colleagues to help me remember a young woman dedicated to change. This young woman's story is one that all of my colleagues, on both sides of the aisle, should keep close to their hearts. Her name is Meredith Miller.

Meredith Miller was a student at the George Washington University. Exactly 1 year ago today, she was returning from a study session when she became the victim of a murder. Meredith was an honor student at Princeton University and was attending graduate school here working toward her Masters Degree. She was pursuing her dream, to make a positive change in this world, but her dream was taken from her.

A member of my staff was a friend of hers and has told me that she was an inspiration to all the people she touched. We can all learn something from the tragic events that took Mary away from her family and friends; do not take anything in this life for granted, live each day to its fullest, and give thanks to the Lord for all that He has given you.

We, as Members of Congress and leaders of this Nation, must work to keep our streets safe and bring criminals to justice. If the dreams of the next generation of leaders, of which Mary was certainly one, are to be fulfilled we must lay that foundation today. We are charged with the duty of ensuring that the hopes and dreams of our Nation's future leaders, such as Mary, can someday be reached.

Meredith, your friends and family want you to know that you may be gone but you will never be forgotten.

THE MILLION MAN MARCH

(Mr. TRAFICANT asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. TRAFICANT. Mr. Speaker, I attended the Million Man March. I thought it was the right thing to do.

Many of my constituents were there. They happened to be black. They also happened to be Americans, and I try to honestly be a Congressman for all people.

The Million Man March was a success. The message was powerful. The themes were responsible: self-responsibility, self-actualization, economic independence, morality, love, parenthood. Those are good messages for all America.

Mr. Speaker, in closing, there is a reality here. The Pope and Billy Graham are great human beings, but the Pope and Billy Graham and all of the religious leaders of the world will not solve the race problem in America. It is going to, in fact, require the help of all people. Congress should join in and commend that march. It was good for the country.

JOIN US IN SAVING MEDICARE

(Mr. METCALF asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. METCALF. Mr. Speaker, it would have been simple for the new Republican majority to ignore Medicare's impending bankruptcy, hide the problem, create a quick fix, and let a Congress 2 or 4 years down the road worry about our seniors. But that is not what the American people elected us to do. The people spoke clearly when they elected the new majority. They expect more from us because they realize those previously in control refused to accept the responsibility of leadership.

The people expect us to do what is right, and we will preserve and protect and strengthen Medicare for the next generation, not just for the next election. We will not play politics with this issue.

I urge all Members of this House to stop the scare tactics and join with us to save Medicare.

CRACK DOWN ON MEDICARE FRAUD

(Mr. BROWN of Ohio asked and was given permission to address the House for 1 minute.)

Mr. BROWN of Ohio. Mr. Speaker, in an editorial on Friday, USA Today said:

> Medicare reform invites doctors to bend the rules. Easing limits on physicians' self-referral is bound to cost the program billions it cannot afford.

USA Today called the deal cut between the American Medical Association and the Speaker a payoff to the AMA. It simply eliminates fraud by legalizing it.

Another newspaper said the Speaker's concessions made an already bad Medicare bill substantially worse. This bill was never designed to give the elderly high-quality care.

What concerns me most about that, Mr. Speaker, is that we can save, and this is a conservative estimate, we can save $100 billion over the next 7 years by going after fraud.

Instead of cutting Medicare $270 billion to give tax breaks to the wealthy, we should go after fraud aggressively. Crack down on fraud, that is what the Medicare debate should be about, not cutting Medicare, raising people's premiums and deductibles and copay $1,000 per person per year so we can give a tax break to the wealthiest Americans.

SETTING THE RECORD STRAIGHT ON MEDICARE

(Mr. LEWIS of Kentucky asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. LEWIS of Kentucky. Mr. Speaker, why are Democrats willing to destroy Medicare and then point an accusing finger at Republicans when we are working hard to save it?

The Democrats' arguments regarding the Republican Medicare plan simply make no sense. They say that Republicans want to destroy Medicare. They say we want to raise premiums and deductibles to pay for a tax cut for the rich. They say we want to close hospitals and deny children and babies access to decent health care. I resent those remarks, especially since my parents are 78 years old and depend on Medicare.

These claims are beyond ludicrous, and by even the most casual scrutiny, no politician in their right mind would ever support such draconian measures, especially when their friends and family would be harmed.

□ 1415

Let us set the record straight. Republicans will provide more choices for seniors. Slowing of Medicare growth cannot and will not be used to fund our tax cuts. Our plan preserves, protects and strengthens Medicare. It is supported by AMA and the U.S. Chamber of Commerce, among others. Come on, Democrats, start making sense. Think before you speak.

PRIVATE ''HEARINGS''

(Miss COLLINS of Michigan asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Miss COLLINS of Michigan. Mr. Speaker, I rise to call attention to one of the many undemocratic practices being utilized by the majority party during this session of the Congress. As I am sure you are aware, certain Members of the U.S. House of Representatives—including some freshmen Members—have been claiming to have held something they carelessly refer to as hearings on legislation introduced—or to be introduced—in this Congress, when in fact some of these so-called hearings were conducted without notice to Members of the opposite political party. Others of these so-called hearings were nothing more than secret meetings with special interest groups, not hearings at all. Some of these same Members have then falsely claimed credit for holding an exaggerated number of hearings on certain important bills—including the bill designed to dismantle the Commerce Department, Medicare/Medicaid, and the Clean Water Act—when in reality they were conducting private meetings that arbitrarily denied participation in the legislative process to members of the Democratic party and all other concerned citizens who might be adversely impacted by such legislation. I think it is time to call a halt to such abuses of the legislative process.

VOTE ''YES'' FOR THE MEDICARE PRESERVATION ACT

(Mr. HEFLEY asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HEFLEY. Mr. Speaker, Medicare is going bankrupt. It took a while, but my Democrat colleagues have finally accepted this fact, and they are now presenting a plan to reform Medicare. This afternoon, I would like to compare their plan with ours.

The Republican plan provides a long-term solution. The Democrat plan ignores the root of Medicare's problems and simply postpones Medicare's bankruptcy for 3 years.

The Republican plan focuses on accountability—it's a fair and realistic plan. The Democrat plan is the epitome of politics as usual—it offers nonsolutions that fail to preserve the program.

In short, the Republican plan saves Medicare from bankruptcy. The Democrat plan saves Democrats for the next election.

Mr. Speaker, the list of major senior groups, medical associations, and others supporting the Republican plan grows every day. I urge my colleagues to vote to save Medicare. Vote ''yes'' for the Medicare Preservation Act.

TAKE MEDICARE PLAN TO THE TRUSTEES

(Mrs. SCHROEDER asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Mrs. SCHROEDER. Mr. Speaker, I think as we talk about Medicare, the real issue is the trustees. We have some nonpoliticians here, trustees, who oversee Medicare. As we hear people on the other side accusing us of MediScare or that their program is better, or whatever they want to say, all I want to say to them is please take your plan to the trustees and see if it fits what the trustees have asked for.

When they were arresting seniors last week, one senior, as her handcuffs were being put on, looked up at the police officer and said: ''Do you have a mother? Why would you do this to me?''

Well, I think all of us do not want to scare our senior citizens, our mothers, or anyone else. The ones they will believe in is the trustees. We will take our plan to the trustees. We dare them to take their plan to the trustees and get their seal of approval.

PRESERVE AND STRENGTHEN MEDICARE

(Mr. KINGSTON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KINGSTON. Mr. Speaker, it is interesting the previous speaker would say that, take your plan to the trustees. They are a bunch of politicians, Reich, Shalala, and Rubin, all appointed by President Clinton. As the gentlewoman well knows, not one of them is an elected Member of Congress. I do not think Members of Congress need to go around pandering to Clinton administration trustees, saying would you please accept our plan. You are all good Democrats.

As the gentlewoman knows, Medicare is a 1964 Blue Cross plan. I want to do something for my mom. I do not want her to drive around in a 1964 Chevrolet Biscayne that we used to have when I was a kid.

We are trying to do what I hope the Democrats are trying to do: Protect, preserve, and strengthen Medicare. We want your help. I agree with the gentlewoman it should not be partisan. It bothers me when I hear countless speech after speech, partisan flame throwing back and forth.

We have to decrease the inflation rate. Medicare is up to an 11-percent inflation rate. We have to bring it down to the 4- to 6-percent rage. We have been accused of cutting Medicare, but we are going from $4,800 to $6,700 per recipient. We want seniors to have the options and choices on physicians, and so forth.

Mrs. SCHROEDER. Mr. Speaker, will the gentleman yield?

Mr. KINGSTON. I yield to the gentlewoman from Colorado.

Mrs. SCHROEDER. Mr. Speaker, I would say for my mom, I would rather have trustees look at it rather than Members of Congress.

Mr. KINGSTON. Mr. Speaker, reclaiming my time, my mom does not trust them. She trusts me.

DO NOT CUT MEDICARE FOR A TAX CUT

(Mr. HILLIARD asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HILLIARD. Mr. Speaker, the Republican plan on Medicare is a falsehood on the people of this country. It is detrimental to all of those persons who are above 60. It is detrimental to everything that America should stand for.

We talked about trustees a minute ago, Mr. Speaker. Every person in this country should have trust in this body, trust to do what is right, especially for those persons who have worked all of their lives and who in the twilight of their years see this body snatch from them their Medicare, their Medicaid benefits, that they are due because of trust that they place in this body. They trust us to do the right thing.

Mr. Speaker, we have failed to do the right thing because we have taken money, we are attempting to take money from Medicare just to support a tax cut for rich.

CORRECTING TECHNICAL ERRORS IN ENROLLMENT OF H.R. 1594, ECONOMICALLY TARGETED INVESTMENTS IN CONNECTION WITH EMPLOYEE BENEFIT PLANS

Mr. GOODLING. Mr. Speaker, I offer a concurrent resolution (H. Con. Res. 108) to correct technical errors in the enrollment of the bill, H.R. 1594, and I ask unanimous consent for its immediate consideration.

The SPEAKER pro tempore (Mr. RIGGS). Is there objection to the request of the gentleman from Pennsylvania?

Mr. OWENS. Mr. Speaker, reserving the right to object, I would ask the gentleman from Pennsylvania [Mr. GOODLING] to explain his request.

Mr. GOODLING. Mr. Speaker, during consideration of the bill H.R. 1594, the Committee of the Whole adopted an amendment offered by Mr. TRAFICANT, which we intended to be language contained in the House Report 104–238. Unfortunately, the language offered was not identical to the House report; hence, this resolution would instruct a correction of the House-passed bill.

Mr. OWENS. Mr. Speaker, further reserving my right to object, I rise in support of the unanimous-consent report.

Mr. Speaker, I withdraw my reservation of objection.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Pennsylvania [Mr. GOODLING]?

There was no objection.

The Clerk read the concurrent resolution, as follows:

H. CON. RES. 108

Resolved by the House of Representatives (the Senate concurring), That, in the enrollment of the bill (H.R. 1594) to place restrictions on the promotion by the Department of Labor and other Federal agencies and instrumentalities of economically targeted investments in connection with employee benefit plans, the Clerk of the House of Representatives shall, in section 5 of the bill, strike ''Nothing'' and all that follows through the end of such section and insert the following: ''Nothing in this Act is intended to affect the ability of the Department of Labor to issue advisory opinions, information letters, technical releases, prohibited transaction exemptions, or other pronouncements interpreting and applying the fiduciary responsibility rules of the Employee Retirement Income Security Act of 1974 in relation to particular factual situations, or exempting specific transactions from the prohibited transaction provisions of such Act (pursuant to sections 406 and 408 of such Act (29 U.S.C. 1106, 1108)).''.

The concurrent resolution was agreed to.

A motion to reconsider was laid on the table.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to the provisions of clause 5 of rule I, the Chair announces that he will postpone further proceedings today on each motion to suspend the rules on which a recorded vote or the yeas and nays are ordered or on which the vote is objected to under clause 4 of rule XV. Such rollcall votes, if postponed, will be taken after debate has concluded on all motions to suspend the rules, but not before 5 p.m. today.

REVERSING SUPREME COURT DECISION IN ADAMS FRUIT VERSUS BARRETT

Mr. GOODLING. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1715) respecting the relationship between workers' compensation benefits and the benefits available under the Migrant and Seasonal Agricultural Worker Protection Act as amended.

The Clerk read as follows:

H.R. 1715

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. WORKERS' COMPENSATION.

(a) AMENDMENTS.—

(1) Section 325 of the Legislative Branch Appropriations Act, 1993 (Public Law 102–392) is repealed.

(2) Section 504(d) of the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C. 1854(d)) is amended to read as follows:

''(d)(1) Notwithstanding any other provision of this Act, where a State workers' compensation law is applicable and coverage is provided for a migrant or seasonal agricultural worker, the workers' compensation benefits shall be the exclusive remedy for loss of such worker under this Act in the case of bodily injury or death in accordance with such State's workers' compensation law.

''(2) The exclusive remedy prescribed by paragraph (1) precludes the recovery under subsection (c) of actual damages for loss from an injury or death but does not preclude recovery under subsection (c) for statutory damages or equitable relief, except that such relief shall not include back or front pay or in any manner, directly or indirectly, expand or otherwise alter or affect (A) a recovery under a State workers' compensation law or (B) rights conferred under a State workers' compensation law.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a)(2) shall apply to all cases in which a final judgment has not been entered.

SEC. 2. EXPANSION OF STATUTORY DAMAGES.

(a) AMENDMENT.—Section 504 of the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C. 1854) is amended by adding after subsection (d) the following:

''(e) If the court finds in an action which is brought by or for a worker under subsection (a) in which a claim for actual damages is precluded because the worker's injury is covered by a State workers' compensation law as provided by subsection (d) that—

''(1)(A) the defendant in the action violated section 401(b) by knowingly requiring or permitting a driver to drive a vehicle for the transportation of migrant or seasonal agricultural workers while under the influence of alcohol or a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)) and the defendant had actual knowledge of the driver's condition, and

''(B) such violation resulted in injury to or death of the migrant or seasonal worker by or for whom the action was brought and such injury or death arose out of and in the course of employment as determined under the State workers' compensation law,

''(2)(A) the defendant violated a safety standard prescribed by the Secretary under section 401(b) which the defendant was determined in a previous judicial or administrative proceeding to have violated, and

''(B) such safety violation resulted in an injury or death described in paragraph (1)(B),

''(3)(A)(i) the defendant willfully disabled or removed a safety device prescribed by the Secretary under section 401(b), or

''(ii) the defendant in conscious disregard of the requirements of section 401(b) failed to provide a safety device required under such section, and

''(B) such disablement, removal, or failure to provide a safety device resulted in an injury or death described in paragraph (1)(B), or

''(4)(A) the defendant violated a safety standard prescribed by the Secretary under section 401(b),

''(B) such safety violation resulted in an injury or death described in paragraph (1)(B), and

''(C) the defendant at the time of the violation of section 401(b) also was—

''(i) an unregistered farm labor contractor in violation of section 101(a), or

''(ii) a person who utilized the services of a farm labor contractor of the type specified in clause (i) without taking reasonable steps to determine that the farm labor contractor possessed a valid certificate of registration authorizing the performance of the farm labor contracting activities which the contractor was requested or permitted to perform with the knowledge of such person,

the court shall award not more than $10,000 per plaintiff per violation with respect to whom the court made the finding described in paragraph (1), (2), (3), or (4), except that multiple infractions of a single provision of this Act shall constitute only one violation

for purposes of determining the amount of statutory damages due to a plaintiff under this subsection and in the case of a class action, the court shall award not more than the lesser of up to $10,000 per plaintiff or up to $500,000 for all plaintiffs in such class action.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to all cases in which a final judgment has not been entered.

SEC. 3. TOLLING OF STATUTE OF LIMITATIONS.

Section 504 of the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C. 1854), as amended by section 2, is amended by adding after subsection (e) the following:

''(f) If it is determined under a State workers' compensation law that the workers' compensation law is not applicable to a claim for bodily injury or death of a migrant or seasonal agricultural worker, the statute of limitations for bringing an action for actual damages for such injury or death under subsection (a) shall be tolled for the period during which the claim for such injury or death under such State workers' compensation law was pending. The statute of limitations for an action for other actual damages, statutory damages, or equitable relief arising out of the same transaction or occurrence as the injury or death of the migrant or seasonal agricultural worker shall be tolled for the period during which the claim for such injury or death was pending under the State workers' compensation law.''.

SEC. 4. DISCLOSURE OF WORKERS' COMPENSATION COVERAGE.

(a) MIGRANT WORKERS.—Section 201(a) of the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C. 1821(a)) is amended by striking ''and'' at the end of paragraph (6), by striking the period at the end of paragraph (7) and inserting ''; and'', and by adding after paragraph (7) the following:

''(8) whether State workers' compensation insurance is provided, and, if so, the name of the State workers' compensation insurance carrier, the name of the policyholder of such insurance, the name and the telephone number of each person who must be notified of an injury or death, and the time period within which such notice must be given.

Compliance with the disclosure requirement of paragraph (8) for a migrant agricultural worker may be met if such worker is given a photocopy of any notice regarding workers' compensation insurance required by law of the State in which such worker is employed. Such worker shall be given such disclosure regarding workers' compensation at the time of recruitment or if sufficient information is unavailable at that time, at the earliest practicable time but in no event later than the commencement of work.''.

(b) SEASONAL WORKERS.—Section 301(a)(1) of the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C. 1831(a)(1)) is amended by striking ''and'' at the end of subparagraph (F), by striking the period at the end of subparagraph (G) and inserting ''; and'', and by adding after subparagraph (G) the following:

''(H) whether State workers' compensation insurance is provided, and, if so, the name of the State workers' compensation insurance carrier, the name of the policyholder of such insurance, the name and the telephone number of each person who must be notified of an injury or death, and the time period within which such notice must be given.

Compliance with the disclosure requirement of subparagraph (H) may be met if such worker is given, upon request, a photocopy of any notice regarding workers' compensation insurance required by law of the State in which such worker is employed.''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect upon the expiration of 90 days after the date final regulations are issued by the Secretary of Labor to implement such amendments.

SEC. 5. LIABILITY INSURANCE.

(a) AMENDMENT.—Section 401(b)(3) of the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C. 1841(b)(3)) is amended to read as follows:

''(3) The level of insurance required under paragraph (1)(C) shall be determined by the Secretary considering at least the factors set forth in paragraph (2)(B) and similar farmworker transportation requirements under State law.''.

(b) REGULATIONS.—Within 180 days of the date of the enactment of this Act, the Secretary of Labor shall promulgate regulations establishing insurance levels under section 401(b)(3) of the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C. 1841(b)(3)) as amended by subsection (a).

(c) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect upon the expiration of 180 days after the date of enactment of this Act or upon the issuance of final regulations under subsection (b), whichever occurs first.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Pennsylvania [Mr. GOODLING] will be recognized for 20 minutes, and the gentleman from New York [Mr. OWENS] will be recognized for 20 minutes.

The Chair recognizes the gentleman from Pennsylvania [Mr. GOODLING].

Mr. GOODLING. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, H.R. 1715 clarifies the relationship between workers' compensation benefits and the private right of action available under Migrant and Seasonal Agricultural Workers Protection Act [MSPA].

H.R. 1715 reverses the Supreme Court's ruling in Adams Fruit Company, Inc. versus Barrett. In that case the Supreme Court held that agricultural workers covered by MSPA could sue for actual damages over injury or death under the private right of action provided under the act, even though the workers are covered for those injuries under State workers' compensation law. In so doing, the Supreme Court rejected the principle of the exclusivity of workers' compensation, which is a fundamental rationale and underpinning for workers' compensation in this country.

As a result of this decision, many agricultural employers in this country face liability for injuries suffered by farm workers even though they have provided workers' compensation coverage for these workers. At the same time, and because not all States require workers' compensation coverage of farm workers, the dual liability of agricultural employers above and beyond workers' compensation insurance serves to discourage more agricultural employers from providing workers' compensation coverage for farm workers.

Mr. Speaker, I introduced H.R. 1715 in May, along with a bipartisan group of cosponsors: Representatives FAZIO, BALLENGER, ANDREWS, FAWELL, STENHOLM, HOEKSTRA, THURMAN, FUNDERBURK, and DOOLEY.

The Economic and Educational Opportunities Committee voted to report H.R. 1715 as introduced on July 22. As introduced, H.R. 1715 was a single section bill that simply reversed the Adams Fruit decision and provided that where State workers' compensation is applicable and coverage is provided, workers' compensation shall be the farm workers exclusive remedy and the employer's sole liability under MSPA for bodily injury or death.

Subsequent to the committee's passage of the bill, several weeks of intensive negotiation took place among the staffs of Republican and Democratic Members along with representatives of national agricultural employer groups and farm workers organizations. As a result of those negotiations, I am today offering a substitute to H.R. 1715 which has the support of not only myself and the other cosponsors of H.R. 1715, but of Members who had concerns with the original bill.

The substitute bill has five sections. Section 1 is similar to the language of the original H.R. 1715, and reverses the Adams Fruit decision. Section 2 provides for increased statutory damages under MSPA under certain limited circumstances described in the bill. Section 3 provides for tolling of the statute of limitations on actions brought under MSPA during the time period in which a claim under State workers' compensation is pending. Section 4 requires disclosure of information regarding workers' compensation coverage to migrant or seasonal agricultural workers. Section 5 requires the Department of Labor to determine the level of liability insurance required of employers engaged in transportation of migrant or seasonal agricultural workers.

I believe that the concerns with this legislation as it was passed by the Economic and Educational Opportunities Committee have been addressed in the substitute that is being offered today. I want to especially thank several Members for their efforts and willingness to work with us in forging this bipartisan agreement: Mr. CLAY, Mr. OWENS, Mr. BERMAN, and Mr. MILLER, along with the group of original cosponsors of H.R. 1715 that I have already mentioned.

For those who may later be reading these comments, I also want to call attention to the fact that a more extensive joint statement of legislative intent reflecting the understandings of myself, Mr. CLAY, Mr. BALLENGER, and Mr. OWENS regarding this substitute to H.R. 1715 is printed in the CONGRESSIONAL RECORD of Friday, October 13, 1995.

It is my hope and expectation that we will quickly pass H.R. 1715 today and that the Senate will likewise pass it on a bipartisan basis and send the bill to the President for his signature. Again, I want to thank many Members from both sides, and particularly Mr. CLAY, Mr. OWENS, Mr. BERMAN, and Mr.

FAZIO for their willingness to work with us to reach this bipartisan agreement on this legislation.

Mr. Speaker, I reserve the balance of my time.

Mr. OWENS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of the amendment offered by the gentleman from Pennsylvania [Mr. GOODLING]. I want to express my appreciation to the distinguished chairman of the Economic and Educational Opportunities Committee, Mr. GOODLING, and to the chairman of the Subcommittee on Work Force Protections, Mr. BALLENGER, for their willingness to seek consensus with the ranking member of our committee, Mr. CLAY, and myself on this legislation. I also want to acknowledge the efforts of three gentlemen from California, Mr. MILLER, Mr. BERMAN, and Mr. FAZIO. The efforts of all three gentlemen have been instrumental in the development of the amendment before us.

The legislation before us is a compromise. Those of us who have sought to represent the interests of farm workers have had to make difficult concessions. Nevertheless, unlike the bill reported by committee, the amendment before us also contains important provisions to ensure that H.R. 1715 reflects the interests of farmworkers as well as growers. Among other provisions, the amendment provides for notification of farmworkers of their rights under State workers' compensation laws, tolls the statute of limitations while State workers' compensation claims are pending, and enhances statutory damages for certain egregious violations of the Migrant and Seasonal Agricultural Workers Protection Act. I refer my colleagues to page E1943 of the CONGRESSIONAL RECORD of last Friday, October 13, in which the gentleman from Pennsylvania [Mr. GOODLING] placed a definitive explanation of the amendment before us.

I fully support the amendment of the gentleman from Pennsylvania and believe this legislation now merits the support of my colleagues. I urge the House to suspend the rules and pass H.R. 1715.

Mr. Speaker, I reserve the balance of my time.

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Mr. GOODLING. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida [Mr. CANADY].

Mr. CANADY of Florida. Mr. Speaker, I yield to the gentleman from North Carolina.

(Mr. BALLENGER asked and was given permission to revise and extend his remarks.)

Mr. BALLENGER. Mr. Speaker, I strongly support H.R. 1715, a bill to clarify the relationship between workers compensation benefits and the private right of action for certain job-related injuries under the Migrant and Seasonal Agricultural Worker Protection Act [MSPA]. In the 1990 decision on the Adams Fruit case, the Supreme Court interpreted MSPA to provide for a private right of action for certain job-related injuries, even if the individual was covered by workers compensation at the time of the injury.

H.R. 1715 would reverse the Supreme Court's ruling, which essentially permits migrant and seasonal farmworkers to seek dual remedies. Agricultural employers could be exposed to potentially enormous liability for damages, in spite of the fact that they have contributed into the workers compensation system. The purpose of workers compensation is to provide a prompt and reasonable remedy to the injured worker without delay or expense. Employers pay into workers compensation programs to avoid being exposed to additional liability. Moreover, in States where agricultural employers are not required to provide workers compensation for migrant and seasonal farmworkers, the Supreme Court's decision may act as a disincentive for employers to provide coverage for those workers.

I urge my colleagues to support Chairman GOODLING's substitute amendment to H.R. 1715. This package of legislative changes to MSPA is fully supported by agricultural employers and farmworker organizations. Not only will this amendment permanently reverse the Adams Fruit decision, it also adds provisions to MSPA which encourage employers to provide safe transportation for farmworkers. This bipartisan agreement has the support of Members on both sides of the aisle. I commend the chairman of the committee, Mr. GOODLING, as well as Mr. CLAY and Mr. OWENS for their success in forging a compromise on this important issue.

Mr. CANADY of Florida. Mr. Speaker, let me begin by thanking Chairman GOODLING for allowing me the opportunity to address the House in support of H.R. 1715, a bill to overturn the Supreme Court's decision in Adams Fruit versus Barrett. And I also want to thank you for all your hard work and dedication in bringing this measure before us today.

Mr. Chairman, in 1990 the Supreme Court, in handing down the Adams Fruit decision, held that injured farmworkers may bring a private right of action under the Migrant and Seasonal Agricultural Worker Protection Act. This was allowed Seven though the workers had already received workers compensation benefits for those same injuries. The implications of this decision have been quite troubling.

First, this decision undermines the exclusivity of workers compensation as a remedy—both in the context of agricultural law and beyond. The workers comp system was designed to be a trade in which employees forego the right to a tort remedy in exchange for expeditious relief without questions of liability or contributory negligence. The Adams Fruit decision does an end-run around this important bargain and opens up employers to costly litigation and open-ended liability for workplace injuries they thought they were insuring themselves against.

Second, it is important to note that farmworkers will also suffer if the Court's decision is allowed to stand. The Adams Fruit decision removes an incentive for agricultural employers to provide workers compensation coverage. In several States, farmworker coverage on workers comp remains optional. The Court's decision provides employers in those States with little reason to exercise that option. For injured farmworkers, lengthy, costly, and uncertain suits are no substitute for the quick and dependable relief of workers compensation.

The bill before us today, Mr. Chairman, ensures that the integrity of this crucial remedy remains available to all farmworkers and all employers. By reversing Adams Fruit and reaffirming the exclusivity of workers compensation, this legislation returns us to Congress' original intent in enacting the statute's current remedial scheme.

This bill is good for agricultural workers and it is good for agricultural employers. I urge my colleagues to support this measure and I look forward to seeing this bill passed by the House today.

Mr. OWENS. Mr. Speaker, I yield such time as he may consume to the gentleman from California [Mr. MILLER].

Mr. MILLER of California. Mr. Speaker, I thank the gentleman for yielding me time, and I rise in support of the compromise version of H.R. 1715, a bill that addresses the Supreme Court decision in the Adams Fruit case.

The bill as originally introduced would have prohibited farmworkers from both receiving workers compensation and suing in court for violations under MSPA [the Migrant and Seasonal Agricultural Worker Protection Act]. The compromise bill we are considering today would achieve that purpose, while at the same time providing some needed safeguards for farmworkers and some deterrence to would-be violators.

I offered in committee an amendment to strengthen the deterrence in the bill by addressing egregious violations of the law, and I am satisfied that the essence of my amendment was incorporated in the compromise version of this bill.

The bill changes the current statutory damages from $500 dollars to $10,000 dollars for egregious cases in which a worker was injured or killed in an accident where alcohol or drugs were involved, where an employer has a history of violations, where the employer willfully makes a vehicle dangerous, or where the employer uses an unregistered farm-labor contractor.

The increase in statutory damages is very much needed to provide a deterrence against violations. As we all know, farmworkers are some of the most exploited workers in America: kids are used in the fields in clear violation of child labor laws; workers are crammed into grossly unsafe, uninsured vehicles that have no seats or safety belts and are injured, maimed and killed; work-cite sanitation is poor or nonexistent; and wages are skimmed by unscrupulous farm-labor contractors.

Enhanced penalties in H.R. 1715 provides needed deterrence to some of these violations, and I therefore urge my colleagues to support this legislation.

Again, Mr. Speaker, I thank the gentleman from New York [Mr. OWENS], for yielding and for his help during these negotiations, and I also thank the chairman of the committee, the gentleman from Pennsylvania [Mr. GOODLING].

Mr. GOODLING. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. OWENS. Mr. Speaker, I yield such time as he may consume to the gentleman from California [Mr. FAZIO].

Mr. FAZIO of California. Mr. Speaker, I thank my friend for yielding. This is a very fair and balanced bill. It has taken a number of years to get calibrated so that we can pass it on suspension.

I want to thank the gentleman from Pennsylvania, Mr. GOODLING, and the gentleman from Missouri, Mr. BILL CLAY, and the gentleman from New York, Mr. MAJOR OWENS, and the gentleman from North Carolina, Mr. CASS BALLENGER, for seeing this effort through to conclusion this year. But I also want to thank my friends, the gentlemen from California, Messrs. HOWARD BERMAN, GEORGE MILLER, and CAL COOLEY, for working so diligently in the last Congress and on into this one to find the right balance so that we could come to closure on this very important issue for agricultural employers and for farmworkers.

Leon Panetta, Rick Lehman, and Austin Murphy, former Members of this body, contributed greatly during their tenure here. In fact, this is the result of 5 years of discussions, but it is a bill that needed to be enacted because it reverses a Supreme Court decision in the Adams Fruit case that unfairly placed agricultural employees in the United States and employers in an untenable position.

Mr. Speaker, agricultural employers were the only people who were eligible both to be sued in court under the tort liability system and required to provide worker's compensation coverage so that they could be sued for workplace injuries by their employees. That double jeopardy needed to be repaired, and, in doing so, we have written a bill that also benefits farmworkers by removing any disincentives to supplying worker's compensation, also encouraging employers to maintain safe transportation practices, the area that was most at issue in terms of these kinds of problems.

Mr. Speaker, it did so by creating four new areas where increased damages are available for transportation related violations. It gives the Secretary of Labor authority to establish appropriate levels of vehicle insurance, given the fact that the Interstate Commerce Commission levels have made it difficult for some involved in farmworker transportation to obtain insurance.

This is a bill that will make sure that farmworkers truly get to exercise their remedy under workers compensation. I think it is a good bill. It certainly is long overdo. I would hope the administration would support it and the President sign it into law. I would ask my colleagues in both parties to sign off on what the gentleman from New York, Mr. OWENS, has described as a cease-fire in the war between the sides on this committee and, I think, a fine example of bipartisanship.

Mr. Speaker, I rise today in support of H.R. 1715, a bill that would reverse the effect of the U.S. Supreme Court in the Adams Fruit Company versus Barrett case. The Supreme Court held that an action for damages under the migrant and seasonal agricultural worker protection was preserved and could be maintained by injured farm workers, even though the farm workers were covered under State workers' compensation for the same injuries suffered in the course of employment.

I commend Chairman BILL GOODLING and ranking member BILL CLAY of the Economic and Educational Opportunities Committee for bringing this bill to the floor along with ranking member MAJOR OWENS and Chairman CASS BALLENGER of the Subcommittee on Workforce Protections. HOWARD BERMAN has also played a leading role in crafting this compromise. But it is also some measure of how long we have been at this that I also want to recognize three former members—Leon Panetta and Rick Lehman from my home State of California, and former subcommittee chairman Austin Murphy—all three of whom were instrumental in moving forward with this compromise during the last Congress.

This bill is the product of 5 years of extensive discussion between representatives of agriculture and farmworkers from throughout the United States. It is a balanced bill, stemming from two hearings before the former Education and Labor Committee, one of which I participated in in California along with then chairman Austin Murphy and my California colleagues CAL DOOLEY, Rick Lehman, HOWARD BERMAN, and GEORGE MILLER. A more recent hearing was held this past summer here in Washington. So the issues addressed in this legislation have been thoroughly considered by the committee and the problems raised are addressed in a balanced way that reflects the realities of the agricultural workplace.

The cornerstone of the bill is the reversal of the Adams Fruit decision, which unfairly places agricultural employers throughout the United States in the position of being the only employers in America who can be mandated under State law to provide workers' compensation—it is mandatory in my own State of California—yet still be sued for unlimited damages in State court for the workplace injuries already compensated under the workers' compensation system.

The decision by the Supreme Court in 1990 was very unfortunate. I felt it was important to respond quickly and strongly, and we temporarily reversed the decision in 1992 as part of the legislative branch appropriations bill, Public Law 192–392.

The legislation before us makes permanent what we accomplished in 1992. Workers' compensation will now be the exclusive remedy for workplace injuries where workers' compensation is provided. Agricultural employers will now be treated the same as all other employers in this country. If workers' compensation is not provided, however, workers will have the right to sue for actual damages under the Migrant and Seasonal Agricultural Worker Protection Act [MSPA].

In addition to providing equity to agricultural employers, this legislation also benefits farmworkers. Because of the transient nature of migrant farmworkers, workers' compensation is very beneficial to them because it provides immediate medical, disability, or death benefits. Without such benefits they would have to sue in a location far from their homes and wait with uncertainty for several years before the court system resolved their claim. Yet with the Adams Fruit decision, agricultural employers in a number of States which make the providing of workers' compensation by employers voluntary have no incentive to provide it, because they still can be sued. But as a result of this legislation, employers will be encouraged to provide workers' compensation to farmworkers.

This bill will also encourage employers to maintain safe transportation practices for their workers. It elevates the statutory damages available to migrant and seasonal farmworkers if those subject to MSPA engage ignore the existing transportation safety requirements of MSPA. The bill creates four new areas where increased damages are available for transportation-related violations. Whatever deterrence to unsafe practices was created by the Adams Fruit decision will be offset more than adequately by the availability of the new transportation-safety provisions.

Finally, the bill gives the Secretary of Labor the authority to establish the appropriate levels of vehicle insurance coverage to be required under MSPA. Currently, the Secretary has to follow ICC-mandated levels. The ICC levels have made it difficult for those involved in farmworker transportation to obtain insurance, thus exposing them to liability and preventing farmworkers from getting needed protection. This provision will allow the Secretary of Labor to balance the need to protect farmworkers' health and safety against undue burdens to agricultural employers and associations and farm labor contractors.

In short, this legislation is an excellent product. It treats agricultural employers the same as other employers, it encourages the provision of workers' compensation to farmworkers, and it encourages transportation safety—a source of many injury claims arising under MSPA. It is evenhanded and fair. While we have taken a long time getting here, the final product is worth the wait. I urge my colleagues to support this bill.

I will also ask the President to sign it, and I believe the administration has given a strong indication in this regard. Secretary of Labor Robert Reich sent a letter to the Economic and Educational Opportunities Committee during its hearing on H.R. 1715, the predecessor to this bill, this past summer and indicated his support for the intent of the legislation in reversing the Adams Fruit decision. He also indicated that farmworker reforms should be a part of it, and the committee has responded to his request. I believe the bill meets the Secretary's and the administration's concerns. It reverses Adams Fruit and contains farmworker reforms. I urge my colleagues to support this long and bipartisan effort, and I look forward to seeing it signed into law.

Mr. OWENS. Mr. Speaker, I yield such time as he may consume to the gentleman from California [Mr. BERMAN].

(Mr. BERMAN asked and was given permission to revise and extend his remarks.)

Mr. BERMAN. Mr. Speaker, I want to thank the chairman of the committee and my colleagues, the gentleman from New York, Mr. OWENS, and the gentleman from Missouri, BILL CLAY, for all of their help in bringing us to this point. I want to make a few comments.

This bill is a very different bill than the bill that was originally introduced or the bill that came out of the Committee on Economic and Educational Opportunity, or whatever that committee is now called. There are a couple of points to make.

First of all, Mr. Speaker, my colleague from Virginia kept talking about the Adams Fruit decision as if it was wrong, because State law somehow would, because State law somehow would preempt Federal law; that is the Migrant and Seasonal Agricultural Worker Protection Act. The court decision was the recognition, everyone knows, that Federal law preempts State law.

On the other hand, Mr. Speaker, there were many weaknesses in that Federal law and some of which we have addressed. This is no longer a bill that allows a grower in a State which has no coverage for farm workers or only partial coverage for farm workers or only voluntary coverage for farm workers to avoid workers compensation and also to immunize himself from any lawsuit. That particular issue has been affected and dealt with through the amendments.

It is also no longer a bill which leaves the inadequate penalty structures of the existing Migrant and Seasonal Agricultural Worker Protection Act, because, in the context of this particular Congress, and in this situation, this seemed to me like, and others, like the best possible arrangement that we could get in terms of the two different needs.

Mr. Speaker, I support this compromise and urge its adoption.

Mr. GOODLING. Mr. Speaker, will the gentleman yield?

Mr. BERMAN. I yield to the gentleman from Pennsylvania.

Mr. GOODLING. Mr. Speaker, we are called the Golden Opportunity Committee.

Mr. BERMAN. I assume golden not having any reference to age?

Mr. GOODLING. Grimes Golden, Golden Delicious.

Mr. BERMAN. Mr. Speaker, I thank the gentleman for his correction of my earlier remarks and yield back the balance of my time.

Mr. OWENS. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. RIGGS). The question is on the motion offered by the gentleman from Pennsylvania [Mr. GOODLING] that the House suspend the rules and pass the bill, H.R. 1715, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. GOODLING. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks on H.R. 1715, a bill to reverse the Supreme Court's decision on Adams Fruit versus Barrett.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Pennsylvania?

There was no objection.

HARRY KIZIRIAN POST OFFICE BUILDING

Mr. MCHUGH. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1606) to designate the United States Post Office building located at 24 Corliss Street, Providence, RI, as the ''Harry Kizirian Post Office Building.''

The Clerk read as follows:

H.R. 1606

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. DESIGNATION.

The United States Post Office building located at 24 Corliss Street, Providence, Rhode Island, shall be known and designated as the ''Harry Kizirian Post Office Building''.

SEC. 2. REFERENCES.

Any reference in a law, map, regulation, document, paper, or other record of the United States to the United States Post Office building referred to in section 1 shall be deemed to be a reference to the ''Harry Kizirian Post Office Building''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New York [Mr. MCHUGH] and the gentlewoman from Michigan [Miss COLLINS] each will be recognized for 20 minutes.

The Chair recognizes the gentleman from New York [Mr. MCHUGH].

Mr. MCHUGH. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the Committee on Government Reform and Oversight voted favorably on the measure before us. Congressman REED of Rhode Island introduced H.R. 1606 and was joined by his State delegation in cosponsoring his bill, as required by committee policy. This legislation designates the main U.S. Post Office in Providence, RI, be named the ''Harry Kizirian Post Office.''

The measure before us honors Mr. Kizirian, a World War II marine veteran and former Providence Postmaster. Mr. Kizirian is Rhode Island's most decorated living veteran and was a career postal worker who held the position of Providence Postmaster for 25 years until his retirement.

Mr. Speaker, I urge our colleagues to support H.R. 1606, a bill which would name a Post Office after the postal employee who served as Postmaster at the facility for 25 years.

Mr. Speaker, I reserve the balance of my time.

Miss COLLINS of Michigan. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I again join my colleague and chairman of the Subcommittee on the Postal Service in support of H.R. 1606, legislation naming the U.S. Post Office, located at 24 Corliss Street in Providence, RI as the, ''Harry Kizirian Post Office Building.''

It gives me great pleasure to acknowledge Mr. Kizirian. He retired from the Post Office as the Postmaster of the facility being named after him and is the most decorated World War II veteran in Providence.

Mr. Speaker, I yield such time as he may consume to my colleague, the gentleman from Rhode Island, Mr. JACK REED, sponsor of the bill.

Mr. REED. Mr. Speaker, I would first like to thank Chairman MCHUGH and the ranking member, Representative COLLINS of the Subcommittee on Postal Service and Chairman CLINGER of the Government Reform and Oversight Committee for helping me bring this bill to the floor. I would also like to thank my colleague from Rhode Island, Mr. KENNEDY, who cosponsored this bill with me, and Senators CHAFEE and PELL, who have introduced an identical bill in the Senate.

This bill would designate the main U.S. Post Office in Providence, RI, as the ''Harry Kizirian Post Office.'' Because some of you may not know Harry, I would like to tell you a little about this outstanding Rhode Island citizen.

Harry Kizirian is the most decorated living veteran in Rhode Island. On Okinawa, he was severely wounded while leading an infantry assault. For his extraordinary heroism, Harry was awarded the Navy Cross, the Bronze Star with V Device for Valor, the Purple Heart with a Gold Star, and the Rhode Island Cross.

When Harry returned to the United States, he immediately went to work at the main post office in Providence where he had worked during high school to support his widowed mother. Displaying the same commitment and teamwork he showed on the frontlines at Okinawa, he worked his way up to an appointment as the Postmaster. He was confirmed by the U.S. Senate in 1961, and held the position of Postmaster for 25 years.

Throughout his career with the Postal Service, Harry also devoted much of his time to the community, serving on numerous boards and committees. Harry served on the board of directors for Butler Hospital, Big Brothers of Rhode Island, Rhode Island Blue Cross, the Rhode Island Heart and Lung Associations, and numerous others.

Harry and his wife, Hazel, also successfully raised a wonderful family.

They have five children: JoAnne, Thomas, Janice, Shakay, and Richard; four grandchildren: Rebecca, Thomas, Joseph, and Janice; and three stepgrandsons: Dylan, Collin, and Matthew.

Harry has served his country in every capacity: in the military, as a civil servant, as a devoted husband and father, and as a loyal American. Harry Kizirian is a source of inspiration for the young and old, and he is a particularly cherished member of Rhode Island's proud and vibrant Armenian community.

This bill would commemorate his generosity and valor for future generations, and it would pay tribute to a remarkable gentleman who has given so much to his Nation, his community, and his family. I urge my colleagues to join me in honoring Harry Kizirian by supporting this bill.

□ 1445

Miss COLLINS of Michigan. Mr. Speaker, I yield as much time as he may consume to the gentleman from Rhode Island [Mr. KENNEDY].

Mr. KENNEDY of Rhode Island. Mr. Speaker, I rise today in strong support of H.R. 1606, a bill that will designate the main post office in Providence, RI, as the ''Harry Kizirian Post Office.''

Harry Kizirian is a shining example of someone who has fully realized the American Dream. A dedicated individual, Harry grew up in my own neighborhood of Mount Pleasant in Providence and worked hard to support his widowed mother.

As a high school graduate, Harry enlisted in the Marine Corps and served in the South Pacific, where he would lead a Marine fire team to victory despite sustaining multiple gunshot wounds. For this selfless heroism, Harry was awarded the Navy Cross, the Bronze Star with a device for Valor, the Purple Heart with a Gold Star, and the Rhode Island Cross.

Harry's service to our country did not end with the Allied Victory in World War II. For the next 35 years, Harry would demonstrate the same commitment to duty and service at the Post Office in Providence as he did during his days in Okinawa. In 1961, the honor and respect that Harry had earned from, not only his colleagues, but also the people of Rhode Island, reached a pinnacle as Harry was confirmed by the Senate as Postmaster.

During his tenure as Postmaster, Harry went well beyond his required duties and served many important social causes. As a leading member of the Big Brothers of Rhode Island, the Providence Human Relations Commission and the Providence Heritage Commission, Harry demonstrated his high regard for his friends and citizens of his community.

Perhaps Harry's greatest achievement is shared with his wife Hazel as they have successfully raised five children, who now have several children of their own, Shakay and Richard. When asked about all his achievements, Harry humbly responded: ''I'm just an ordinary American boy who loves dealing with people from all walks of life.''

In my opinion, Harry Kizirian is anything but ordinary. Raised with a strong Armenian heritage, Harry is a living tribute to his family, his friends, and his country.

Mr. Speaker, I am honored to stand with my colleague, JACK REED, to offer this bill which will honor Harry Kizirian's commitment and generosity for generations to come.

Miss COLLINS of Michigan. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. MCHUGH. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time

The SPEAKER pro tempore (Mr. RIGGS). The question is on the motion offered by the gentleman from New York [Mr. MCHUGH], that the House suspend the rules and pass the bill, H.R. 1606.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. MCHUGH. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 1606, the bill just considered.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

WINFIELD SCOTT STRATTON POST OFFICE

Mr. MCHUGH. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1026) to designate the U.S. Post Office building located at 201 East Pikes Peak Avenue in Colorado Springs, CO, as the ''Winfield Scott Stratton Post Office.''

The Clerk read as follows:

H.R. 1026

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. DESIGNATION.

The United States Post Office building located at 201 East Pikes Peak Avenue, Colorado Springs, Colorado, shall be known and designated as the ''Winfield Scott Stratton Post Office.''

SEC. 2 REFERENCES.

Any reference in a law, map, regulation, document, paper, or other record of the United States to the building referred to in section 1 shall be deemed to be a reference to the ''Winfield Scott Stratton Post Office''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New York [Mr. MCHUGH] will be recognized for 20 minutes, and the gentlewoman from Michigan [Miss COLLINS] will be recognized for 20 minutes.

The Chair recognizes the gentleman from New York [Mr. MCHUGH].

Mr. MCHUGH. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am pleased to report that the legislation before us, H.R. 1026, was approved unanimously by the Committee on Government Reform and Oversight. This legislation, designating the U.S. Post Office located at 201 East Pikes Peak Avenue, Colorado Springs, CO, be named the ''Winfield Scott Stratton Post Office,'' was introduced by the gentleman from Colorado [Mr. HEFLEY], and was cosponsored by his full State Delegation, as required by committee policy.

H.R. 1026 honors the late Mr. Stratton, a Colorado Springs philanthropist and benefactor. Mr. Stratton was one of many adventurers who came to Colorado seeking their fortune. He literally struck gold in discovering a rich deposit in the mines of Cripple Creek, CO.

Mr. Stratton believed it was the duty of the fortunate to use their wealth in the development of their community. In keeping with this personal philosophy, he dedicated the rest of his life to helping others less fortunate and to advancing the development of Colorado Springs and Colorado.

Mr. Speaker, I support the passage of H.R. 1026 and urge our colleagues to do the same.

Mr. Speaker, I yield such time as he may consume to the gentleman from Colorado [Mr. HEFLEY].

Mr. HEFLEY. Mr. Speaker, I would like to first thank the gentleman from Pennsylvania [Mr. CLINGER] the chairman of the full committee, and the gentleman from New York [Mr. MCHUGH], chairman of the Subcommittee on the Postal Service, for allowing H.R. 1026 to be brought up on the Suspension Calendar today. I think it is a fitting tribute to a man who gave so much to Colorado, and particularly to the area of Colorado that I am fortunate enough to represent.

Mr. Speaker, H.R. 1026, which as has been indicated, will designate the U.S. Post Office building located at 201 Pikes Peak Avenue in Colorado Springs, CO, as the ''Winfield Scott Stratton Post Office.''

Working as a carpenter and as a prospector, Mr. Stratton became wealth after finding gold in Cripple Creek, CO. His sudden wealth allowed him to pursue life's pleasures any way that he would like to do it, but instead he spent much of his life and much of his fortune helping those that were less fortunate. In addition to helping the needy, he also played an integral part in the development of Colorado Springs as a community by providing money for a city hall, a new courthouse, the streetcar system, and perhaps his most generous, important contribution that he made was the Myron Stratton Home, which was a foster home for children and for impoverished elderly.

Mr. Speaker, it still exists today. It is an interesting concept in that they had children who did not have parents.

In the early days it was an orphanage, but it was not the image that you have of the Charles Dickens orphanage. It was an orphanage where the kids that went there had many of the things that money could buy in terms of living a good life under the circumstances of not having a family. And he combined that with elderly people to create an intergenerational type of concept that has worked very well even to this day.

Especially pertinent to H.R. 1026, is that Mr. Stratton sold the property where the post office is located, and which we are asking to be named today, to the Federal Government for half its value on the condition that they would build a post office there.

Mr. Speaker, I did not know Mr. Stratton. He was before my time there. But I have been able to see his work in the Colorado Springs area over the years.

Finally, Mr. Speaker, I would like to thank Mr. John Zorack, a former resident of the Stratton Home, who has worked closely with me to see that this fitting tribute be enacted. I would add that H.R. 1026 has the support of the Colorado Delegation and the Colorado Springs City Council. Mr. Speaker, I thank the gentleman from New York [Mr. MCHUGH] for his support of this legislation.

Mr. MCHUGH. Mr. Speaker, I reserve the balance of my time.

Miss COLLINS of Michigan. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I join my colleague and chairman of the Subcommittee on the Postal Service in support of H.R. 1026, legislation designating the U.S. Post Office at 201 East Pikes Peak Avenue in Colorado Springs, CO, as the Winfield Scott Stratton Post Office.

The late Mr. Stratton was well known as a great philanthropist and most deserving to have a Post Office named after him.

Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. MCHUGH. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York [Mr. MCHUGH] that the House suspend the rules and pass the bill, H.R. 1026.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. MCHUGH. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 1026 the bill just considered.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

BIOTECHNICAL PROCESS PATENTS

Mr. MOORHEAD. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 587) to amend title 35, United States Code, with respect to patents on biotechnological processes.

The Clerk read as follows:

H.R. 587

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

BIOTECHNOLOGICAL PROCESS PATENTS

SEC. 101. CONDITIONS FOR PATENTABILITY; NONOBVIOUS SUBJECT MATTER.

Section 103 of title 35, United States Code, is amended—

(1) by designating the first paragraph as subsection (a);

(2) by designating the second paragraph as subsection (c); and

(3) by inserting after the first paragraph the following:

''(b)(1) Notwithstanding subsection (a), and upon timely election by the applicant for patent to proceed under this subsection, a 'biotechnological process' using or resulting in a composition of matter that is novel under section 102 and nonobvious under subsection (a) of this section shall be considered nonobvious if—

''(A) claims to the process and the composition of matter are contained in either the same application for patent or in separate applications having the same effective filing date; and

''(B) the composition of matter, and the process at the time it was invented, were owned by the same person or subject to an obligation of assignment to the same person.

''(2) A patent issued on a process under paragraph (1)—

''(A) shall also contain the claims to the composition of matter used in or made by that process; or

''(B) shall, if such composition of matter is claimed in another patent, be set to expire on the same date as such other patent, notwithstanding section 154.

''(3) For purposes of paragraph (1), the term 'biotechnological process' means—

''(A) a process of genetically altering or otherwise inducing a single- or multi-celled organism to—

''(i) express an exogenous nucleotide sequence,

''(ii) inhibit, eliminate, augment, or alter expression of an endorgenous nucleotide sequence, or

''(iii) express a specific physiological characteristic not naturally associated with said organism;

''(B) cell fusion procedures yielding a cell line that expresses a specific a specific protein, such as a monoclonal antibody; and

''(C) a method of using a product produced by a process defined by (A) or (B), or a combination of (A) and (B).''.

SEC. 102. PRESUMPTION OF VALIDITY; DEFENSES.

Section 282 of title 35, United States Code, is amended by inserting after the second sentence of the first paragraph the following: ''Notwithstanding the preceding sentence, if a claim to a composition of matter is held invalid and that claim was the basis of a determination of nonobviousness under section 103(b)(1), the process shall no longer be considered nonobvious solely on the basis of section 103(b)(1).''.

SEC. 103. EFFECTIVE DATE.

The amendments made by section 101 shall apply to any application for patent filed on or after the date of enactment of this Act and to any application for patent pending on such date of enactment, including (in either case) an application for the reissuance of a patent.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from California [Mr. MOORHEAD] will be recognized for 20 minutes, and the gentlewoman from Colorado [Mrs. SCHROEDER] will be recognized for 20 minutes.

The Chair recognizes the gentleman from California [Mr. MOORHEAD].

(Mr. MOORHEAD asked and was given permission to revise and extend his remarks.)

Mr. MOORHEAD. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 587, the Biotech Process Patent Protection Act of 1995. I would like to commend the gentleman from Virginia [Mr. BOUCHER] and thank him for working so hard with us over the past 5 years to make this legislation possible. I also want to thank the gentlewoman from Colorado [Mrs. SCHRODER] for her support and cooperation.

From an economic point of view, the U.S. biotech industry has gone from zero revenues and zero jobs 15 years ago to $8 billion and 103,000 jobs today. The White House Council on Competitiveness projects a $30 to $50 billion market for biotech products by the year 2000, and many in the industry believe this estimate to be conservative.

Companies that depend heavily on research and development are especially vulnerable to foreign competitors who copy and sell their products without permission. The reason that high-technology companies are so vulnerable is that for them the cost of innovation, rather than the cost of production, is the key cost incurred in bringing a product to market. The award of patient protection ensures a greater degree of protection for businesses in the United States who make major investment in innovation.

The House Judiciary Committee took the first step in protecting innovation in 1988 when the Congress enacted two bills which I introduced relating to process patents and reform of the International Trade Commission. However, our work will not be complete until we enact this legislation. This bill modifies the test for obtaining a process patent, a problem that was created by In Re Durden (1985), a case frequently criticized and cited by the Patent Office as grounds for denial of biotech patents. The legislation impacts only one element of patentability of biotech processes and that is the element of nonobviousness. The process must still satisfy all other requirements of patentability.

Because so many of the biotech inventions are protected by patents, the future of that industry depends greatly on what Congress does to protect U.S. patents from unfair foreign competition. America's foreign competitors, most of whom have invested comparatively little in biotechnology research,

have targeted the biotech industry for major and concerted action.

In conclusion, Mr. Speaker, this is important legislation. The biotech industry is an immensely important industry started in the United States with many labs housed in California. In the decade ahead, biotechnology research will improve the lives and health of virtually every American family. It will put people to work and it will save people's lives. Identical legislation has already passed the other body, S. 1111.

I urge a favorable vote on H.R. 587.

□ 1500

Mr. Speaker, I reserve the balance of my time.

Mrs. SCHROEDER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 587.

One of the most important tasks faced by the Intellectual Property Subcommittee is to make sure that our patent law keeps pace with technological change. The importance of this task is nowhere more evident than in the area of biotechnology, where industry has encountered difficulty in obtaining timely and adequate process patent protection because of conflicting case law and inconsistency in PTO examination practices resulting from the conflicting holdings of relevant court cases.

It is critical to our economy and to our quality of life that biotechnology research and development can take place on a level playing vis-a-vis foreign competitors, and without excessive uncertainty or delay in patent protection.

This bill will achieve those goals: It will mitigate the uncertainty in the patent examination process, and it will bring about a more level playing field for U.S. biotechnology companies and their overseas competitors.

The bill before us today is supported by the administration, and it has bipartisan support from the Judiciary Committee. The roadblocks faced by predecessor bills have been removed by making the bill biotechnology industry-specific. I believe, through this bill, that we have fashioned a fair and effective means of addressing the uncertainties and inadequacies in patent law as it applies to biotechnology, and I urge my colleagues to support it.

I also want to acknowledge the hard work on both sides of the aisle over a number of years to resolve this problem. Our subcommittee chairman, the gentleman from California, the gentleman from Massachusetts [Mr. FRANK], and the gentleman from Virginia [Mr. BOUCHER], have all worked diligently to address this problem, and I congratulate them for their efforts.

Mr. Speaker, it looks like this is the year it will really happen. I congratulate them.

Mr. Speaker, I reserve the balance of my time.

Mr. MOORHEAD. Mr. Speaker, I yield 5 minutes to the gentleman from California [Mr. ROHRABACHER].

Mr. ROHRABACHER. Mr. Speaker, I rise to support this bill, which will establish an objective standard to determine if biotechnology patent applications involve nonobvious material.

This standard is necessary to clarify patent law for one of our Nation's most important growth industries, the biotechnology industry, and I congratulate Chairman MOORHEAD for his leadership in bringing this bill to the floor.

We need, however, to deal with the fundamental problem, the lack of a minimum guaranteed patent term. For over 100 years, this country had a patent term of 17 years from grant. That term acted to encourage and reward innovation. Unfortunately, the GATT implementing legislation established an uncertain term of 20 years from filing. Many biotech patents take years to be issued, which under the new rules results in a vastly reduced patent term biotech companies and anyone else whose breakthrough technology takes longer than usual to get through the Patent Office are victimized. I have introduced legislation, H.R. 359, which will establish a term of 20 years from filing or 17 years from grant, whichever is longer. That's consistent with the GATT agreement and with our Nation's tradition of strong intellectual property rights. That tradition has fueled the growth of new, dynamic industries in America and will continue to do so as long as this Congress continues to respect the creativity and hard work of the Nation's independent inventors.

The subcommittee chairman and I continue to have honest differences on this and other issues, such as unconditional publication of all patent applications 18 months after filing. Such publication will allow unscrupulous people to copy and infringe on the inventions of biotech companies and other innovative industries. I am encouraged that we will have a hearing on November 1 to examine these problems, just as I am encouraged that the chairman has shown concern for the biotechnology industry with H.R. 587. I look forward to the day when the Congress will decide, on this floor, up or down, on whether to restore the fundamental patent rights of all of America's inventors.

Mrs. SCHROEDER. Mr. Speaker, I yield such time as he may consume to the gentleman from Michigan [Mr. CONYERS], the distinguished ranking member.

Mr. CONYERS. Mr. Speaker, first of all, congratulations to the gentleman from California [Mr. MOORHEAD], the subcommittee chairman, and the gentlewoman from Colorado [Mrs. SCHROEDER], who has worked with him across the years.

I am a cosponsor and strong supporter of H.R. 587 which resolves the confusion created by two conflicting appellate court decisions on the standards for granting process patents to biotechnology companies.

Though this is a matter that could have been resolved by the courts, the matter has been pending since November 1992 without any resolution. Further delays could be costly to American biotech companies.

The legislation prohibits the Patent and Trademark Office from rejecting applications for process patents using or resulting in a composition of matter that is novel and nonobvious.

This legislation serves the important purpose of protecting the rights of American companies to bring patent infringement claims against importers who are able to evade the law by processing cells outside the United States and importing the finished products into the United States on the technicality that there has been no use of patented host cells in the United States. Without a process patent, the importation of the final product cannot be challenged. I urge passage of this worthy bill.

Mrs. SCHROEDER. Mr. Speaker, I yield 3 minutes to the gentleman from Massachusetts [Mr. FRANK] who has been working on this bill forever and ever, and I am sure is glad to see it on the floor.

Mr. FRANK of Massachusetts. Mr. Speaker, I thank the ranking minority member of the subcommittee for yielding.

The chairman has been congratulated and deservedly. This is an important issue that has more complexity than one might think, as we explain it, I think the reaction is, well, gee, this is just so straightforward. But people should understand that there were issues to be resolved, whether this was going to be a change in patent law in general or whether it was better to make it specific to an industry.

There were traditional practitioners of patent law who had objections to this. What we are doing today and, as I understand the parliamentary situation since we are taking up the Senate bill, we are sending this right to the President. One of the striking things about the current situation people should understand is that on those occasions, and I say this is clearly in order because it explains why we are doing what we are doing and why we are taking the Senate bill. On those occasions when the U.S. Senate can be persuaded to do anything at all, one then grabs it and takes it and does not take the chance of sending it back.

So this will now go right to the President for signature. It is a mark of the successful chairmanship of the gentleman from California that this important piece of legislation will within a few weeks be law. We are not simply passing a bill through the House today, but we are sending it to the President who we know is going to sign it. I can simply say I am not an expert on this as are few of my colleagues but, talking to the people in the biotechnology industry in Massachusetts, this was

very high on their list of things that will help. It is one of these things that does good in a multiplicity of ways.

In the first place, it will help produce the products, and this is of greatest importance, that cure people, that alleviate illnesses. We are here doing something that will facilitate better health care for people, and that is of course fundamental.

It will also promote jobs in the State that I represent and in other States because it will help the biotechnology industry improve its market. It will help exports. It will help the American economy.

So this is something which has all positive and no negative. But, despite that, given the world we live in, it was not an easy thing to bring it here. As I said, this may look to people like kind of a ho-hum thing. It is to the credit of the gentleman from California and his management of this issue that something that had a lot of pitfalls and a lot of potential controversies does come forward in this guise.

I also wanted to express my appreciation to the gentleman who spoke just before me, the other Member from California, he has his own very strong interests in patent issues, some of which I agree with him on, and his willingness to collaborate with us in getting this bill through is something I very much appreciate, thanks to the ranking member for her leadership, to the chairman. I think we have shown today that we are able to function in a very positive way to advance a number of goals.

Mrs. SCHROEDER. Mr. Speaker, I yield such time as he may consume to the gentleman from Virginia [Mr. BOUCHER]. He has worked so hard on this bill. I am sure for his sake he is very happy to have this happen.

(Mr. BOUCHER asked and was given permission to revise and extend his remarks.)

Mr. BOUCHER. Mr. Speaker, for the last several years, I have been involved in a very productive partnership with my friend and colleague, the gentleman from California [Mr. MOORHEAD], in an effort to extend better patent protection to the biotechnology industry. Today I am pleased to be here on the floor joining with him as we culminate that effort and as we send to the President legislation that will enact this much needed reform.

The biotechnology industry is a bright promise for our Nation's success in the international market of the future. The industry was originated and developed in the United States. This uniquely American enterprise is expected to confer an annual benefit of approximately $50 billion on the American economy by the year 2000. And even today, it has created more than 100,000 new highly paid, highly skilled jobs in this economy.

But more important than its economic contributions are the benefits biotechnology is bringing to the fields of medicine and agriculture. Through biotechnology, new strains of plants are being produced that are resistant to disease, that can thrive in hostile terrain, and can survive adverse climatic conditions.

Through biotechnology, new human drugs are on the market today that, when administered to heart attack victims, save lives by dissolving dangerous blood clots.

Other drugs treat anemia, reducing need for blood transfusions in patients who are suffering from chronic kidney failure. And human growth hormone is today enriching the lives of children throughout the world.

American companies are now developing treatments or even potential cures for a variety of hard to treat diseases, including AIDS, Alzheimer's disease, cystic fibrosis, and Lou Gehrig's disease.

And yet the promise of biotechnology is seriously challenged today by a simple and obvious inadequacy in America's patent law. That inadequacy opens the door for foreign firms to expropriate American inventions and compete in this country directly with the inventing firm. In essence, the patent law confers and advantage on foreign companies not enjoyed by the American inventing firm and actually encourages a pilfering of United States creativity. We have examples today of that very practice occurring.

It is that defect in the patent law that H.R. 587 is designed to address. In most cases, biotechnology products are genetically engineered forms of chemicals which naturally occur. The goal of biotechnology is to create the chemicals in larger and commercially viable quantities. To do that, the company engineers a host cell to produce the product. The firm then treats the host cell with a frequently straightforward and well-known process to create the naturally occurring chemical in commercially viable quantities.

The company cannot patent the end product because it occurs in nature. All the company is doing is creating that product in larger quantities. The company can patent the host cell but, under current law, the use of a patented host cell abroad to manufacture a product for importation into the United States is not an infringement of the American host cell patent.

Under a series of court decisions, most prominently In Re Durden, the inventor has great difficulty in obtaining a patent on the process that is used to produce the product. The legislation that the gentleman from California [Mr. MOORHEAD] has brought to the House today and which I have been pleased to work with him on over the last several years will open the door to a more certain award of process patents.

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In turn the biotechnology firms that have the assurance of receiving those process patents will exhibit a greater willingness to make research investments totaling hundreds of millions of dollars on an annual basis, the very research investments that are essential to sustain and advance this highly important American industry.

Mr. Speaker, I am pleased to urge support for this measure and passage of it by the House, and I join with our colleague, the gentleman from Massachusetts [Mr. FRANK], in commending the gentleman from California for his legislative skill which has brought the measure to this point which, when added to the Senate bill already passed by that body, can then send this measure directly to the President for his signature and for enactment into law. It is a positive measure. It will advance a very important industry, and I join with the gentleman from California [Mr. MOORHEAD] in strongly urging its passage.

Mrs. SCHROEDER. Mr. Speaker, I have no further speakers, and I yield back the balance of my time.

Mr. MOORHEAD. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I wish the congratulate each member of our subcommittee for the hard work they have done on this legislation over a long period of time. This is a fine moment today as we get this bill adopted, and every single Member of both sides of the aisle have worked hard, put their effort in. I know that the gentleman from Virginia [Mr. BOUCHER] has really put his heart and soul into it over a period of years, and we had Bill Hughes, who was the chairman of our subcommittee, who worked hard on it. We have the gentleman from Colorado [Mrs. SCHROEDER] and the ranking member of the full committee. Everyone in our committee has really worked on this: The gentleman from Virginia [Mr. BOUCHER], the gentleman from Massachusetts [Mr. FRANK], the gentleman from Oklahoma [Mr. COBURN], the gentleman from Wisconsin [Mr. SENSENBRENNER], and I want to thank each and every one of them for the product that we are presenting.

Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore. (Mr. RIGGS). The question is on the motion offered by the gentleman from California [Mr. MOORHEAD] that the House suspend the rules and pass the bill, H.R. 587.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended, and the bill was passed.

A motion to reconsider was laid on the table.

Mr. MOORHEAD. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the Senate bill (S. 1111) to amend title 35, United States Code, with respect to patents on biotechnological processes, and ask for its immediate consideration in the House.

The Clerk read the title of the Senate bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

Mrs. SCHROEDER. Mr. Speaker, reserving the right to object, I do so to yield to the gentleman from California [Mr. MOORHEAD] to explain the purpose of the request.

Mr. MOORHEAD. Mr. Speaker, will the gentlewoman yield?

Mrs. Schroeder. I yield to the gentleman from California.

Mr. MOORHEAD. Mr. Speaker, this is the companion Senate bill. This action will enable the bill to go immediately to the President. The Senate bill is identical to the recent House-passed legislation.

Mrs. SCHROEDER. Mr. Speaker, I salute the gentleman for this very adept explanation. That is exactly what we hope to do, get this right to the President. I thank the gentleman for being so expeditious.

Mr. Speaker, I withdraw my reservation of objection.

The Speaker pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

The Clerk read the Senate bill, as follows:

S. 1111

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. BIOTECHNOLOGICAL PROCESS PATENTS; CONDITIONS FOR PATENTABILITY; NONOBVIOUS SUBJECT MATTER.

Section 103 of title 35, United States code is amended—

(1) by designating the first paragraph as subsection (a);

(2) by designating the second paragraph as subsection (c); and

(3) by inserting after the first paragraph the following:

''(b)(1) Notwithstanding subsection (a), and upon timely election by the applicant for patent to proceed under this subsection, a biotechnological process using or resulting in a composition of matter that is novel under section 102 and nonobvious under subsection (a) of this section shall be considered nonobvious if—

''(A) claims to the process and the composition of matter are contained in either the same application for patent or in separate applications having the same effective filing date; and

''(B) the composition of matter, and the process at the time it was invented, were owned by the same person or subject to an obligation of assignment to the same person.

''(2) A patent issued on a process under paragraph (1)—

''(A) shall also contain the claims to the composition of matter used in or made by that process, or

''(B) shall, if such composition of matter is claimed in another patent, be set to expire on the dame date as such other patent, notwithstanding section 154.

''(3) For purposes of paragraph (1), the term 'biotechnological process' means—

''(A) a process of genetically altering or otherwise inducing a single- or multi-celled organism to—

''(i) express an exogenous nucleotide sequence,

''(ii) inhibit, eliminate, augment, or alter expression of an endogenous nucleotide sequence, or

''(iii) express a specific physiological characteristic not naturally associated with said organism;

''(B) cell fusion procedures yielding a cell line that expresses a specific protein, such as a monoclonal antibody; and

''(C) a method of using a product produced by a process defined by (A) or (B), or a combination of (A) and (B).''.

SEC. 2. PRESUMPTION OF VALIDITY; DEFENSES.

Section 282 of title 35, United States code, is amended by inserting after the second sentence of the first paragraph the following: ''Notwithstanding the preceding sentence, if a claim to a composition of matter is held invalid and that claim was the basis of a determination of nonobviousness under section 103(b)(1), the process shall no longer be considered nonobvious solely on the basis of section 103(b)(1).''.

SEC. 3. EFFECTIVE DATE.

The amendments made by section 1 shall apply to any application for patent filed on or after the date of enactment of this Act and to any application for patent pending on such date of enactment, including (in either case) an application for the reissuance of a patent.

The Senate bill was ordered to be read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

APPOINTMENT OF CONFEREES ON H.R. 1655, INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 1996

Mr. COMBEST. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the bill (H.R. 1655) to authorize appropriations for fiscal year 1996 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes, with a Senate amendment thereto, disagree to the Senate amendment, and agree to the conference asked by the Senate.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas? The Chair hears none and, without objection, appoints the following conferees:

From the Permanent Select Committee on Intelligence, for consideration of the House bill, and the Senate amendment, and modifications committed to conference:

Messrs. COMBEST, DORNAN, YOUNG of Florida, HANSEN, LEWIS of California, GOSS, SHUSTER, MCCOLLUM, CASTLE, DICKS, RICHARDSON, DIXON, TORRICELLI, COLEMAN, SKAGGS, and Ms. PELOSI.

From the Committee on National Security, for the consideration of defense tactical intelligence and related activities:

Messrs. SPENCE, STUMP, and DELLUMS.

As additional conferees from the Committee on International Relations, for consideration of section 303 of the House bill, and section 303 of the Senate amendment, and modifications committed to conference:

Messrs. GILMAN, SMITH of New Jersey, and BERMAN.

There was no objection.

DIGITAL PERFORMANCE RIGHT IN SOUND RECORDINGS ACT OF 1995

Mr. MOORHEAD. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1506) to amend title 17, United States Code, to provide an exclusive right to perform sound recordings publicly by means of digital transmissions, and for other purposes, as amended.

The Clerk read as follows:

H.R. 1506

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Digital Performance Right in Sound Recordings Act of 1995''.

SEC. 2. EXCLUSIVE RIGHTS IN COPYRIGHTED WORKS.

Section 106 of title 17, United States Code, is amended—

(1) in paragraph (4) by striking ''and'' after the semicolon;

(2) in paragraph (5) by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(6) in the case of sound recordings, to perform the copyrighted work publicly by means of a digital audio transmission.''.

SEC. 3. SCOPE OF EXCLUSIVE RIGHTS IN SOUND RECORDINGS.

Section 114 of title 17, United States Code, is amended—

(1) in subsection (a) by striking ''and (3)'' and inserting ''(3) and (6)'';

(2) in subsection (b) in the first sentence by striking ''phonorecords, or of copies of motion pictures and other audiovisual works,'' and inserting ''phonorecords or copies'';

(3) by striking subsection (d) and inserting:

''(d) LIMITATIONS ON EXCLUSIVE RIGHT.—Notwithstanding the provisions of section 106(6)—

''(1) EXEMPT TRANSMISSIONS AND RETRANSMISSIONS.—The performance of a sound recording publicly by means of a digital audio transmission, other than as a part of an interactive service, is not an infringement of section 106(6) if the performance is part of—

''(A)(i) a nonsubscription transmission other than a retransmission;

''(ii) an initial nonsubscription retransmission made for direct reception by members of the public of a prior or simultaneous incidental transmission that is not made for direct reception by members of the public; or

''(iii) a nonsubscription broadcast transmission;

''(B) a retransmission of a nonsubscription broadcast transmission: Provided, That, in the case of a retransmission of a radio station's broadcast transmission—

''(i) the radio station's broadcast transmission is not willfully or repeatedly retransmitted more than a radius of 150 miles from the site of the radio broadcast transmitter, however—

''(I) the 150 mile limitation under this clause shall not apply when a nonsubscription broadcast transmission by a radio station licensed by the Federal Communications Commission is retransmitted on a nonsubscription basis by a terrestrial broadcast station, terrestrial translator, or terrestrial repeater licensed by the Federal Communications Commission; and

''(II) in the case of a subscription retransmission of a nonsubscription broadcast retransmission covered by subclause (I), the 150 mile radius shall be measured from the transmitter site of such broadcast retransmitter;

''(ii) the retransmission is of radio station broadcast transmissions that are—

''(I) obtained by the retransmitter over the air;

''(II) not electronically processed by the retransmitter to deliver separate and discrete signals; and

''(III) retransmitted only within the local communities served by the retransmitter;

''(iii) the radio station's broadcast transmission was being retransmitted to cable systems (as defined in section 111(f)) by a satellite carrier on January 1, 1995, and that retransmission was being retransmitted by cable systems as a separate and discrete signal, and the satellite carrier obtains the radio station's broadcast transmission in an analog format: Provided, That the broadcast transmission being retransmitted may embody the programming of no more than one radio station; or

''(iv) the radio station's broadcast transmission is made by a noncommercial educational broadcast station funded on or after January 1, 1995, under section 396(k) of the Communications Act of 1934 (47 U.S.C. 396(k)), consists solely of noncommercial educational and cultural radio programs, and the retransmission, whether or not simultaneous, is a nonsubscription terrestrial broadcast retransmission; or

''(C) a transmission that comes within any of the following categories:

''(i) a prior or simultaneous transmission incidental to an exempt transmission, such as a feed received by and then retransmitted by an exempt transmitter: Provided, That such incidental transmissions do not include any subscription transmission directly for reception by members of the public;

''(ii) a transmission within a business establishment, confined to its premises or the immediately surrounding vicinity;

''(iii) a retransmission by any retransmitter, including a multichannel video programming distributor as defined in section 602(12) of the Communications Act of 1934 (47 U.S.C. 522(12)), of a transmission by a transmitter licensed to publicly perform the sound recording as a part of that transmission, if the retransmission is simultaneous with the licensed transmission and authorized by the transmitter; or

''(iv) a transmission to a business establishment for use in the ordinary course of its business: Provided, That the business recipient does not retransmit the transmission outside of its premises or the immediately surrounding vicinity, and that the transmission does not exceed the sound recording performance complement. Nothing in this clause shall limit the scope of the exemption in clause (ii).

''(2) SUBSCRIPTION TRANSMISSIONS.—In the case of a subscription transmission not exempt under subsection (d)(1), the performance of a sound recording publicly by means of a digital audio transmission shall be subject to statutory licensing, in accordance with subsection (f) of this section, if—

''(A) the transmission is not part of an interactive service;

''(B) the transmission does not exceed the sound recording performance complement;

''(C) the transmitting entity does not cause to be published by means of an advance program schedule or prior announcement the titles of the specific sound recordings or phonorecords embodying such sound recordings to be transmitted;

''(D) except in the case of transmission to a business establishment, the transmitting entity does not automatically and intentionally cause any device receiving the transmission to switch from one program channel to another; and

''(E) except as provided in section 1002(e) of this title, the transmission of the sound recording is accompanied by the information encoded in that sound recording, if any, by or under the authority of the copyright owner of that sound recording, that identifies the title of the sound recording, the featured recording artist who performs on the sound recording, and related information, including information concerning the underlying musical work and its writer.

''(3) LICENSES FOR TRANSMISSIONS BY INTERACTIVE SERVICES.—

''(A) No interactive service shall be granted an exclusive license under section 106(6) for the performance of a sound recording publicly by means of digital audio transmission for a period in excess of 12 months, except that with respect to an exclusive license granted to an interactive service by a licensor that holds the copyright to 1,000 or fewer sound recordings, the period of such license shall not exceed 24 months: Provided, however, That the grantee of such exclusive license shall be ineligible to receive another exclusive license for the performance of that sound recording for a period of 13 months from the expiration of the prior exclusive license.

''(B) The limitation set forth in subparagraph (A) of this paragraph shall not apply if—

''(i) the licensor has granted and there remain in effect licenses under section 106(6) for the public performance of sound recordings by means of digital audio transmission by at least 5 different interactive services: Provided, however, That each such license must be for a minimum of 10 percent of the copyrighted sound recordings owned by the licensor that have been licensed to interactive services, but in no event less than 50 sound recordings; or

''(ii) the exclusive license is granted to perform publicly up to 45 seconds of a sound recording and the sole purpose of the performance is to promote the distribution or performance of that sound recording.

''(C) Notwithstanding the grant of an exclusive or nonexclusive license of the right of public performance under section 106(6), an interactive service may not publicly perform a sound recording unless a license has been granted for the public performance of any copyrighted musical work contained in the sound recording: Provided, That such license to publicly perform the copyrighted musical work may be granted either by a performing rights society representing the copyright owner or by the copyright owner.

''(D) The performance of a sound recording by means of a retransmission of a digital audio transmission is not an infringement of section 106(6) if—

''(i) the retransmission is of a transmission by an interactive service licensed to publicly perform the sound recording to a particular member of the public as part of that transmission; and

''(ii) the retransmission is simultaneous with the licensed transmission, authorized by the transmitter, and limited to that particular member of the public intended by the interactive service to be the recipient of the transmission.

''(E) For the purposes of this paragraph—

''(i) a 'licensor' shall include the licensing entity and any other entity under any material degree of common ownership, management, or control that owns copyrights in sound recordings; and

''(ii) a 'performing rights society' is an association or corporation that licenses the public performance of nondramatic musical works on behalf of the copyright owner, such as the American Society of Composers, Authors and Publishers, Broadcast Music, Inc., and SESAC, Inc.

''(4) RIGHTS NOT OTHERWISE LIMITED.—

''(A) Except as expressly provided in this section, this section does not limit or impair the exclusive right to perform a sound recording publicly by means of a digital audio transmission under section 106(6).

''(B) Nothing in this section annuls or limits in any way—

''(i) the exclusive right to publicly perform a musical work, including by means of a digital audio transmission, under section 106(4);

''(ii) the exclusive rights in a sound recording or the musical work embodied therein under sections 106(1), 106(2) and 106(3); or

''(iii) any other rights under any other clause of section 106, or remedies available under this title, as such rights or remedies exist either before or after the date of enactment of the Digital Performance Right in Sound Recordings Act of 1995.

''(C) Any limitations in this section on the exclusive right under section 106(6) apply only to the exclusive right under section 106(6) and not to any other exclusive rights under section 106. Nothing in this section shall be construed to annul, limit, impair or otherwise affect in any way the ability of the owner of a copyright in a sound recording to exercise the rights under sections 106(1), 106(2) and 106(3), or to obtain the remedies available under this title pursuant to such rights, as such rights and remedies exist either before or after the date of enactment of the Digital Performance Right in Sound Recordings Act of 1995.''; and

(4) by adding after subsection (d) the following:

''(e) AUTHORITY FOR NEGOTIATIONS.—

''(1) Notwithstanding any provision of the antitrust laws, in negotiating statutory licenses in accordance with subsection (f), any copyright owners of sound recordings and any entities performing sound recordings affected by this section may negotiate and agree upon the royalty rates and license terms and conditions for the performance of such sound recordings and the proportionate division of fees paid among copyright owners, and may designate common agents on a nonexclusive basis to negotiate, agree to, pay, or receive payments.

''(2) For licenses granted under section 106(6), other than statutory licenses, such as for performances by interactive services or performances that exceed the sound recording performance complement—

''(A) copyright owners of sound recordings affected by this section may designate common agents to act on their behalf to grant licenses and receive and remit royalty payments: Provided, That each copyright owner shall establish the royalty rates and material license terms and conditions unilaterally, that is, not in agreement, combination, or concert with other copyright owners of sound recordings; and

''(B) entities performing sound recordings affected by this section may designate common agents to act on their behalf to obtain licenses and collect and pay royalty fees: Provided, That each entity performing sound recordings shall determine the royalty rates and material license terms and conditions unilaterally, that is, not in agreement, combination, or concert with other entities performing sound recordings.

''(f) LICENSES FOR NONEXEMPT SUBSCRIPTION TRANSMISSIONS.—

''(1) No later than 30 days after the enactment of the Digital Performance Right in Sound Recordings Act of 1995, the Librarian of Congress shall cause notice to be published in the Federal Register of the initiation of voluntary negotiation proceedings for the purpose of determining reasonable terms and rates of royalty payments for the activities specified by subsection (d)(2) of this section during the period beginning on the effective date of such Act and ending on December 31, 2000. Such terms and rates shall distinguish among the different types of digital audio transmission services then in operation. Any copyright owners of sound recordings or any entities performing sound recordings affected by this section may submit to the Librarian of Congress licenses covering such activities with respect to such sound recordings. The parties to each negotiation proceeding shall bear their own costs.

''(2) In the absence of license agreements negotiated under paragraph (1), during the 60-day period commencing 6 months after publication of the notice specified in paragraph (1), and upon the filing of a petition in accordance with section 803(a)(1), the Librarian of Congress shall, pursuant to chapter 8, convene a copyright arbitration royalty panel to determine and publish in the Federal Register a schedule of rates and terms which, subject to paragraph (3), shall be binding on all copyright owners of sound recordings and entities performing sound recordings. In addition to the objectives set forth in section 801(b)(1), in establishing such rates and terms, the copyright arbitration royalty panel may consider the rates and terms for comparable

types of digital audio transmission services and comparable circumstances under voluntary license agreements negotiated as provided in paragraph (1). The Librarian of Congress shall also establish requirements by which copyright owners may receive reasonable notice of the use of their sound recordings under this section, and under which records of such use shall be kept and made available by entities performing sound recordings.

''(3) License agreements voluntarily negotiated at any time between one or more copyright owners of sound recordings and one or more entities performing sound recordings shall be given effect in lieu of any determination by a copyright arbitration royalty panel or decision by the Librarian of Congress.

''(4)(A) Publication of a notice of the initiation of voluntary negotiation proceedings as specified in paragraph (1) shall be repeated, in accordance with regulations that the Librarian of Congress shall prescribe—

''(i) no later than 30 days after a petition is filed by any copyright owners of sound recordings or any entities performing sound recordings affected by this section indicating that a new type of digital audio transmission service on which sound recordings are performed is or is about to become operational; and

''(ii) in the first week of January, 2000 and at 5-year intervals thereafter.

''(B)(i) The procedures specified in paragraph (2) shall be repeated, in accordance with regulations that the Librarian of Congress shall prescribe, upon the filing of a petition in accordance with section 803(a)(1) during a 60-day period commencing—

''(I) six months after publication of a notice of the initiation of voluntary negotiation proceedings under paragraph (1) pursuant to a petition under paragraph (4)(A)(i); or

''(II) on July 1, 2000 and at 5-year intervals thereafter.

''(ii) The procedures specified in paragraph (2) shall be concluded in accordance with section 802.

''(5)(A) Any person who wishes to perform a sound recording publicly by means of a nonexempt subscription transmission under this subsection may do so without infringing the exclusive right of the copyright owner of the sound recording—

''(i) by complying with such notice requirements as the Librarian of Congress shall prescribe by regulation and by paying royalty fees in accordance with this subsection; or

''(ii) if such royalty fees have not been set, by agreeing to pay such royalty fees as shall be determined in accordance with this subsection.

''(B) Any royalty payments in arrears shall be made on or before the twentieth day of the month next succeeding the month in which the royalty fees are set.

''(g) PROCEEDS FROM LICENSING OF SUBSCRIPTION TRANSMISSIONS.—

''(1) Except in the case of a subscription transmission licensed in accordance with subsection (f) of this section—

''(A) a featured recording artist who performs on a sound recording that has been licensed for a subscription transmission shall be entitled to receive payments from the copyright owner of the sound recording in accordance with the terms of the artist's contract; and

''(B) a nonfeatured recording artist who performs on a sound recording that has been licensed for a subscription transmission shall be entitled to receive payments from the copyright owner of the sound recording in accordance with the terms of the nonfeatured recording artist's applicable contract or other applicable agreement.

''(2) The copyright owner of the exclusive right under section 106(6) of this title to publicly perform a sound recording by means of a digital audio transmission shall allocate to recording artists in the following manner its receipts from the statutory licensing of subscription transmission performances of the sound recording in accordance with subsection (f) of this section:

''(A) 2½ percent of the receipts shall be deposited in an escrow account managed by an independent administrator jointly appointed by copyright owners of sound recordings and the American Federation of Musicians (or any successor entity) to be distributed to nonfeatured musicians (whether or not members of the American Federation of Musicians) who have performed on sound recordings.

''(B) 2½ percent of the receipts shall be deposited in an escrow account managed by an independent administrator jointly appointed by copyright owners of sound recordings and the American Federation of Television and Radio Artists (or any successor entity) to be distributed to nonfeatured vocalists (whether or not members of the American Federation of Television and Radio Artists) who have performed on sound recordings.

''(C) 45 percent of the receipts shall be allocated, on a per sound recording basis, to the recording artist or artists featured on such sound recording (or the persons conveying rights in the artists' performance in the sound recordings).

''(h) LICENSING TO AFFILIATES.—

''(1) If the copyright owner of a sound recording licenses an affiliated entity the right to publicly perform a sound recording by means of a digital audio transmission under section 106(6), the copyright owner shall make the licensed sound recording available under section 106(6) on no less favorable terms and conditions to all bona fide entities that offer similar services, except that, if there are material differences in the scope of the requested license with respect to the type of service, the particular sound recordings licensed, the frequency of use, the number of subscribers served, or the duration, then the copyright owner may establish different terms and conditions for such other services.

''(2) The limitation set forth in paragraph (1) of this subsection shall not apply in the case where the copyright owner of a sound recording licenses—

''(A) an interactive service; or

''(B) an entity to perform publicly up to 45 seconds of the sound recording and the sole purpose of the performance is to promote the distribution or performance of that sound recording.

''(i) NO EFFECT ON ROYALTIES FOR UNDERLYING WORKS.—License fees payable for the public performance of sound recordings under section 106(6) shall not be taken into account in any administrative, judicial, or other governmental proceeding to set or adjust the royalties payable to copyright owners of musical works for the public performance of their works. It is the intent of Congress that royalties payable to copyright owners of musical works for the public performance of their works shall not be diminished in any respect as a result of the rights granted by section 106(6).

''(j) DEFINITIONS.—As used in this section, the following terms have the following meanings:

''(1) An 'affiliated entity' is an entity engaging in digital audio transmissions covered by section 106(6), other than an interactive service, in which the licensor has any direct or indirect partnership or any ownership interest amounting to 5 percent or more of the outstanding voting or non-voting stock.

''(2) A 'broadcast' transmission is a transmission made by a terrestrial broadcast station licensed as such by the Federal Communications Commission.

''(3) A 'digital audio transmission' is a digital transmission as defined in section 101, that embodies the transmission of a sound recording. This term does not include the transmission of any audiovisual work.

''(4) An 'interactive service' is one that enables a member of the public to receive, on request, a transmission of a particular sound recording chosen by or on behalf of the recipient. The ability of individuals to request that particular sound recordings be performed for reception by the public at large does not make a service interactive. If an entity offers both interactive and non-interactive services (either concurrently or at different times), the non-interactive component shall not be treated as part of an interactive service.

''(5) A 'nonsubscription' transmission is any transmission that is not a subscription transmission.

''(6) A 'retransmission' is a further transmission of an initial transmission, and includes any further retransmission of the same transmission. Except as provided in this section, a transmission qualifies as a 'retransmission' only if it is simultaneous with the initial transmission. Nothing in this definition shall be construed to exempt a transmission that fails to satisfy a separate element required to qualify for an exemption under section 114(d)(1).

''(7) The 'sound recording performance complement' is the transmission during any 3-hour period, on a particular channel used by a transmitting entity, of no more than—

''(A) 3 different selections of sound recordings from any one phonorecord lawfully distributed for public performance or sale in the United States, if no more than 2 such selections are transmitted consecutively; or

''(B) 4 different selections of sound recordings—

''(i) by the same featured recording artist; or

''(ii) from any set or compilation of phonorecords lawfully distributed together as a unit for public performance or sale in the United States,

if no more than three such selections are transmitted consecutively:

Provided, That the transmission of selections in excess of the numerical limits provided for in clauses (A) and (B) from multiple phonorecords shall nonetheless qualify as a sound recording performance complement if the programming of the multiple phonorecords was not willfully intended to avoid the numerical limitations prescribed in such clauses.

''(8) A 'subscription' transmission is a transmission that is controlled and limited to particular recipients, and for which consideration is required to be paid or otherwise given by or on behalf of the recipient to receive the transmission or a package of transmissions including the transmission.

''(9) A 'transmission' includes both an initial transmission and a retransmission.''.

SEC. 4. MECHANICAL ROYALTIES IN DIGITAL PHONORECORD DELIVERIES.

Section 115 of title 17, United States Code, is amended—

(1) in subsection (a)(1)—

(A) in the first sentence by striking out ''any other person'' and inserting in lieu thereof ''any other person, including those who make phonorecords or digital phonorecord deliveries,''; and

(B) in the second sentence by inserting before the period '', including by means of a digital phonorecord delivery'';

(2) in subsection (c)(2) in the second sentence by inserting ''and other than as provided in paragraph (3),'' after ''For this purpose,'';

(3) by redesignating paragraphs (3), (4), and (5) of subsection (c) as paragraphs (4), (5), and (6), respectively, and by inserting after paragraph (2) the following new paragraph:

''(3)(A) A compulsory license under this section includes the right of the compulsory licensee to distribute or authorize the distribution of a phonorecord of a nondramatic musical work by means of a digital transmission which constitutes a digital phonorecord delivery, regardless of whether the digital transmission is also a public performance of the sound recording under section 106(6) of this title or of any nondramatic musical work embodied therein under section 106(4) of this title. For every digital phonorecord delivery by or under the authority of the compulsory licensee—

''(i) on or before December 31, 1997, the royalty payable by the compulsory licensee shall be the royalty prescribed under paragraph (2) and chapter 8 of this title; and

''(ii) on or after January 1, 1998, the royalty payable by the compulsory licensee shall be the royalty prescribed under subparagraphs (B) through (F) and chapter 8 of this title.

''(B) Notwithstanding any provision of the antitrust laws, any copyright owners of nondramatic musical works and any persons entitled to obtain a compulsory license under subsection (a)(1) may negotiate and agree upon the terms and rates of royalty payments under this paragraph and the proportionate division of fees paid among copyright owners, and may designate common agents to negotiate, agree to, pay or receive such royalty payments. Such authority to negotiate the terms and rates of royalty payments includes, but is not limited to, the authority to negotiate the year during which the royalty rates prescribed under subparagraphs (B) through (F) and chapter 8 of this title shall next be determined.

''(C) During the period of June 30, 1996, through December 31, 1996, the Librarian of Congress shall cause notice to be published in the Federal Register of the initiation of voluntary negotiation proceedings for the purpose of determining reasonable terms and rates of royalty payments for the activities specified by subparagraph (A) during the period beginning January 1, 1998, and ending on the effective date of any new terms and rates established pursuant to subparagraph (C), (D) or (F), or such other date (regarding digital phonorecord deliveries) as the parties may agree. Such terms and rates shall distinguish between (i) digital phonorecord deliveries where the reproduction or distribution of a phonorecord is incidental to the transmission which constitutes the digital phonorecord delivery, and (ii) digital phonorecord deliveries in general. Any copyright owners of nondramatic musical works and any persons entitled to obtain a compulsory license under subsection (a)(1) may submit to the Librarian of Congress licenses covering such activities. The parties to each negotiation proceeding shall bear their own costs.

''(D) In the absence of license agreements negotiated under subparagraphs (B) and (C), upon the filing of a petition in accordance with section 803(a)(1), the Librarian of Congress shall, pursuant to chapter 8, convene a copyright arbitration royalty panel to determine and publish in the Federal Register a schedule of rates and terms which, subject to subparagraph (E), shall be binding on all copyright owners of nondramatic musical works and persons entitled to obtain a compulsory license under subsection (a)(1) during the period beginning January 1, 1998, and ending on the effective date of any new terms and rates established pursuant to subparagraph (C), (D) or (F), or such other date (regarding digital phonorecord deliveries) as may be determined pursuant to subparagraphs (B) and (C). Such terms and rates shall distinguish between (i) digital phonorecord deliveries where the reproduction or distribution of a phonorecord is incidental to the transmission which constitutes the digital phonorecord delivery, and (ii) digital phonorecord deliveries in general. In addition to the objectives set forth in section 801(b)(1), in establishing such rates and terms, the copyright arbitration royalty panel may consider rates and terms under voluntary license agreements negotiated as provided in subparagraphs (B) and (C). The royalty rates payable for a compulsory license for a digital phonorecord delivery under this section shall be established de novo and no precedential effect shall be given to the amount of the royalty payable by a compulsory licensee for digital phonorecord deliveries on or before December 31, 1997. The Librarian of Congress shall also establish requirements by which copyright owners may receive reasonable notice of the use of their works under this section, and under which records of such use shall be kept and made available by persons making digital phonorecord deliveries.

''(E)(i) License agreements voluntarily negotiated at any time between one or more copyright owners of nondramatic musical works and one or more persons entitled to obtain a compulsory license under subsection (a)(1) shall be given effect in lieu of any determination by the Librarian of Congress. Subject to clause (ii), the royalty rates determined pursuant to subparagraph (C), (D) or (F) shall be given effect in lieu of any contrary royalty rates specified in a contract pursuant to which a recording artist who is the author of a nondramatic musical work grants a license under that person's exclusive rights in the musical work under sections 106(1) and (3) or commits another person to grant a license in that musical work under sections 106(1) and (3), to a person desiring to fix in a tangible medium of expression a sound recording embodying the musical work.

''(ii) The second sentence of clause (i) shall not apply to—

''(I) a contract entered into on or before June 22, 1995, and not modified thereafter for the purpose of reducing the royalty rates determined pursuant to subparagraph (C), (D) or (F) or of increasing the number of musical works within the scope of the contract covered by the reduced rates, except if a contract entered into on or before June 22, 1995, is modified thereafter for the purpose of increasing the number of musical works within the scope of the contract, any contrary royalty rates specified in the contract shall be given effect in lieu of royalty rates determined pursuant to subparagraph (C), (D) or (F) for the number of musical works within the scope of the contract as of June 22, 1995; and

''(II) a contract entered into after the date that the sound recording is fixed in a tangible medium of expression substantially in a form intended for commercial release, if at the time the contract is entered into, the recording artist retains the right to grant licenses as to the musical work under sections 106(1) and 106(3).

''(F) The procedures specified in subparagraphs (C) and (D) shall be repeated and concluded, in accordance with regulations that the Librarian of Congress shall prescribe, in each fifth calendar year after 1997, except to the extent that different years for the repeating and concluding of such proceedings may be determined in accordance with subparagraphs (B) and (C).

''(G) Except as provided in section 1002(e) of this title, a digital phonorecord delivery licensed under this paragraph shall be accompanied by the information encoded in the sound recording, if any, by or under the authority of the copyright owner of that sound recording, that identifies the title of the sound recording, the featured recording artist who performs on the sound recording, and related information, including information concerning the underlying musical work and its writer.

''(H)(i) A digital phonorecord delivery of a sound recording is actionable as an act of infringement under section 501, and is fully subject to the remedies provided by sections 502 through 506 and section 509, unless—

''(I) the digital phonorecord delivery has been authorized by the copyright owner of the sound recording; and

''(II) the owner of the copyright in the sound recording or the entity making the digital phonorecord delivery has obtained a compulsory license under this section or has otherwise been authorized by the copyright owner of the musical work to distribute or authorize the distribution, by means of a digital phonorecord delivery, of each musical work embodied in the sound recording.

''(ii) Any cause of action under this subparagraph shall be in addition to those available to the owner of the copyright in the nondramatic musical work under subsection (c)(6) and section 106(4) and the owner of the copyright in the sound recording under section 106(6).

''(I) The liability of the copyright owner of a sound recording for infringement of the copyright in a nondramatic musical work embodied in the sound recording shall be determined in accordance with applicable law, except that the owner of a copyright in a sound recording shall not be liable for a digital phonorecord delivery by a third party if the owner of the copyright in the sound recording does not license the distribution of a phonorecord of the nondramatic musical work.

''(J) Nothing in section 1008 shall be construed to prevent the exercise of the rights and remedies allowed by this paragraph, paragraph (6), and chapter 5 in the event of a digital phonorecord delivery, except that no action alleging infringement of copyright may be brought under this title against a manufacturer, importer or distributor of a digital audio recording device, a digital audio recording medium, an analog recording device, or an analog recording medium, or against a consumer, based on the actions described in such section.

''(K) Nothing in this section annuls or limits (i) the exclusive right to publicly perform a sound recording or the musical work embodied therein, including by means of a digital transmission, under sections 106(4) and 106(6), (ii) except for compulsory licensing under the conditions specified by this section, the exclusive rights to reproduce and distribute the sound recording and the musical work embodied therein under sections 106(1) and 106(3), including by means of a digital phonorecord delivery, or (iii) any other rights under any other provision of section 106, or remedies available under this title, as such rights or remedies exist either before or after the date of enactment of the Digital Performance Right in Sound Recordings Act of 1995.

''(L) The provisions of this section concerning digital phonorecord deliveries shall not apply to any exempt transmissions or retransmissions under section 114(d)(1). The exemptions created in section 114(d)(1) do not expand or reduce the rights of copyright owners under section 106(1) through (5) with respect to such transmissions and retransmissions.''; and

(5) by adding after subsection (c) the following:

''(d) DEFINITION.—As used in this section, the following term has the following meaning: A 'digital phonorecord delivery' is each individual delivery of a phonorecord by digital transmission of a sound recording which results in a specifically identifiable reproduction by or for any transmission recipient of a phonorecord of that sound recording, regardless of whether the digital transmission is also a public performance of the sound recording or any nondramatic musical work embodied therein. A digital phonorecord delivery does not result from a real-time, noninteractive subscription transmission of a sound recording where no reproduction of the sound recording or the musical work embodied therein is made from the inception of the transmission through to its receipt by the transmission recipient in order to make the sound recording audible.''.

SEC. 5. CONFORMING AMENDMENTS.

(a) DEFINITIONS.—Section 101 of title 17, United States Code, is amended by inserting after the definition of ''device'', ''machine'', or ''process'' the following:

''A 'digital transmission' is a transmission in whole or in part in a digital or other non-analog format.''.

(b) LIMITATIONS ON EXCLUSIVE RIGHTS: SECONDARY TRANSMISSIONS.—Section 111(c)(1) of title 17, United States Code, is amended in the first sentence by inserting ''and section 114(d)'' after ''of this subsection''.

(c) LIMITATIONS ON EXCLUSIVE RIGHTS: SECONDARY TRANSMISSIONS OF SUPERSTATIONS AND NETWORK STATIONS FOR PRIVATE HOME VIEWING.—

(1) Section 119(a)(1) of title 17, United States Code, is amended in the first sentence by inserting ''and section 114(d)'' after ''of this subsection''.

(2) Section 119(a)(2)(A) of title 17, United States Code, is amended in the first sentence by inserting ''and section 114(d)'' after ''of this subsection''.

(d) COPYRIGHT ARBITRATION ROYALTY PANELS.—

(1) Section 801(b)(1) of title 17, United States Code, is amended in the first and second sentences by striking ''115'' each place it appears and inserting ''114, 115,''.

(2) Section 802(c) of title 17, United States Code, is amended in the third sentence by striking ''section 111, 116, or 119,'' and inserting ''section 111, 114, 116, or 119, any person entitled to a compulsory license under section 114(d), any person entitled to a compulsory license under section 115,''.

(3) Section 802(g) of title 17, United States Code, is amended in the third sentence by inserting ''114,'' after ''111,''.

(4) Section 802(h)(2) of title 17, United States Code, is amended by inserting ''114,'' after ''111,''.

(5) Section 803(a)(1) of title 17, United States Code, is amended in the first sentence by striking ''115'' and inserting ''114, 115'' and by striking ''and (4)'' and inserting ''(4) and (5)''.

(6) Section 803(a)(3) of title 17, United States Code, is amended by inserting before the period ''or as prescribed in section 115(c)(3)(D)''.

(7) Section 803(a) of title 17, United States Code, is amended by inserting after paragraph (4) the following new paragraph:

''(5) With respect to proceedings under section 801(b)(1) concerning the determination of reasonable terms and rates of royalty payments as provided in section 114, the Librarian of Congress shall proceed when and as provided by that section.''.

SEC. 6. EFFECTIVE DATE.

This Act and the amendments made by this Act shall take effect 3 months after the date of enactment of this Act, except that the provisions of sections 114(e) and 114(f) of title 17, United States Code (as added by section 3 of this Act) shall take effect immediately upon the date of enactment of this Act.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from California [Mr. MOORHEAD] will be recognized for 20 minutes, and the gentlewoman from Colorado [Mrs. SCHROEDER] will be recognized for 20 minutes.

The Chair recognizes the gentleman from California [Mr. MOORHEAD].

(Mr. MOORHEAD asked and was given permission to revise and extend his remarks.)

Mr. MOORHEAD. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 1506, the Digital Performance Right in Sound Recordings Act of 1995. I would like to thank the gentlewoman from Colorado [Mrs. SCHROEDER] for her cooperation and hard work on this important legislation. I also want to commend the gentleman from Michigan [Mr. CONYERS], an original cosponsor of H.R. 1506, for his support and leadership in bringing about the compromise that made this legislation possible. The Subcommittee on Courts and Intellectual Property began last Congress to try and construct legislation to take care of what all parties agree is a likely problem for U.S. record companies and the people who sing and play music. The problem concerns home subscription services for the digital transmission of music offered by different companies. This type of service permits the home subscriber, for a monthly fee, to select music. The company providing a subscription service can purchase a single record and play it for hundreds of subscribers and by so doing displace record sales.

Under current law, owners of almost every kind of copyright work have exclusive rights to authorize the public performance of that work. But sound recordings and the artists and companies that produce them have no such performance rights. Records sold at a store is the primary source of income for the record companies and for the singers. When a song is played on the radio or a digital audio cable service, neither the musicians who perform the work nor the record company have a legal right to control or receive compensation. H.R. 1506 will provide a very limited right for this purpose.

This new right is limited in that it only applies to digital audio transmission services that are sold primarily to the home. It does not apply to traditional radio and TV broadcasts, or to background music services, such as Muzak or 3M nor does it apply to public radio, restaurants, department stores, hotels, amusement parks.

The purpose of this legislation is to insure that performing artists, record companies and others whose livelihood depends upon effective copyright protection for sound recordings will be protected as new technologies affect the ways in which their creative works are marketed.

WHAT ABOUT THE PUBLIC INTEREST

The Department of Justice's Antitrust Division reviewed the compromise agreement and sent a letter to the subcommittee supporting the compromise saying that it will ''advance competition'' and by adopting the two amendments that they recommended the new language will preclude the recording companies from acting as a cartel and exploiting the combined market power associated with the pooling of intellectual property rights and thereby prevent the driving up of prices that consumers will have to pay for their product.

This legislation will also permit the development of new technologies that will be used and enjoyed by the consumer. It will also provide the consumer with access to a variety of choices of new entertainment which will be regulated by the market. We must remember that our copyright industries contribute more to the U.S. economy and employ more workers than any single manufacturing sector in the United States Between 1977 and 1993, employment in the U.S. copyright industries more than doubled to 3 million workers, which is 2.5 percent of the total U.S. work force. During the same period, the U.S. copyright industry employment grew almost four times the annual rate of the whole economy—2.6 percent versus 0.7 percent. In 1993, the U.S. copyright industries achieved estimated foreign sales of $45.8 billion. After automobiles and parts, the copyright industry is the second largest industry in exports.

Again, I want to thank the committee members for their patience and support and I would like to congratulate the parties of interest for working together and coming up with what I believe is a good, solid piece of legislation, that's both good for the industry and good for the American consumer.

Mr. Speaker, in conclusion, this legislation is the first step in bringing our copyright industries closer to the information superhighway. As we enter the digital and information age, the protection of America's intellectual property is essential. It's essential for two reasons. First, for the development, use, and advancement of new technology, and second, such protection will encourage more creative works from which society is the ultimate benefactor.

I am not aware of any opposition to this legislation. It has the support of the American Federation of Musicians, the American Federation of Television and Radio Artists, the record industries, the songwriters, the radio and TV broadcast industry, and the administration.

I urge a favorable vote on H.R. 1506.

Mr. Speaker, I reserve the balance of my time.

Mrs. SCHROEDER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 1506, and yield myself such time as I may consume.

I strongly support the establishment in our copyright law of a digital performance right in sound recordings. In the digital age, creation of this right becomes imperative if we are to ensure that creators and copyright owners receive fair compensation for their property.

I also want to emphasize how important the creation of this right is with respect to our efforts to ensure strong protection for intellectual property on a global basis. While complete harmonization of our copyright laws with those of other countries is not possible, it is difficult for us to persuade other countries to protect intellectual property if our own laws are not sufficiently strong.

I particularly want to commend the various interested parties who have spent long and arduous hours in negotiations with respect to this bill. Under the leadership of our subcommittee chairman, the gentleman from California, we have seen the parties negotiate successfully in a way that makes the bill before us today as strong as possible. I think the result is a positive one for all parties involved, and I urge my colleagues to support it.

Mr. Speaker, I reserve the balance of my time.

□ 1530

Mr. MOORHEAD. Mr. Speaker, I yield such time as he may consume to the gentleman from Wisconsin [Mr. SENSENBRENNER].

Mr. SENSENBRENNER. Mr. Speaker, I rise in support for H.R. 1506, the Digital Performance Right in Sound Recordings Act of 1995. This bill gives recording artists and their recording companies copyright protection over the transmission of digital sound recordings. Under current law, songwriters, but not recording artists or companies, receive royalties when their music is played on radio or television.

Artists and companies receive much of their compensation through the sale of compact discs, records, and tapes that are often promoted on radio and television. However, new interactive services are being created which allow consumers to use their TV's and computers to order any recording at any time. These subscriber services threaten sales of CD's, records and tapes. With this legislation recording artists will have a performance right in digital transmissions which will afford them the opportunity to receive compensation when their performances are transmitted digitally. Presently, under American copyright law, owners of almost every kind of copyrighted work have exclusive rights to authorize the public performance of that work. It is time to provide recording artists and companies some copyright protection.

H.R. 1506 is equally important for what it doesn't do. This bill does not require businesses, such as bars and restaurants to pay an additional performance royalty when they play music. Such businesses should be allowed the play ''incidental'' or background music without having to pay fees to music performers. Background music is not now and will never be a substitute for consumer purchases of prerecorded music.

I congratulate Chairman MOORHEAD and all the parties who contributed to the negotiations on this issue and made this compromise legislation possible. H.R. 1506 brings copyright law up-to-date to accommodate the new digital technologies in today's marketplace. I strongly urge its passage.

Mrs. SCHROEDER. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from Michigan [Mr. CONYERS], the ranking member of the subcommittee.

(Mr. CONYERS asked and was given permission to revise and extend his remarks.)

Mr. CONYERS. Mr. Speaker, my congratulations again to the chairman of the subcommittee, the gentleman from California [Mr. MOORHEAD], who was joined by the gentlewoman from Colorado [Mrs. SCHROEDER] and the gentleman from California [Mr. BERMAN] to make sure that we got to this point.

Mr. Speaker, I rise in support of the measure. The sounds of harmony that I hear today on H.R. 1506 are, well, music to my ears.

I am truly delighted that our friends in the recording industry, the performing rights societies, the broadcasters and the background music services have, under the auspices of this subcommittee, done the tough job of hammering out a compromise agreement that is acceptable to all.

When Mr. MOORHEAD asked me to join with him as a lead cosponsor of H.R. 1506, we both knew that such a process would be essential to the final resolution of this matter. We both knew that H.R. 1506 as introduced would not be the final word, but rather the logical starting point of a process which broke down in an unfortunate manner last year.

Three major issues were critical to the resolution of this matter.

First, there was disagreement about the exclusive rights to license performances of digital music on interactive or audio-on-demand services and whether this would be a right shared with the performance rights societies.

Second, the commercial music services, like MUZAK, wanted an exemption such as provided for them in the House bill but not in the Senate bill.

Third, there was a dispute over when there is a digital delivery which affects the record companies' ability to collect royalties.

Under your leadership, Mr. Speaker, these three sticky matters have now become transformed into harmonic convergence.

The agreement requires the interactive music distributor to obtain licenses from both the record company, for the sound recording, and from the performing rights societies, for the musical composition. That seems fair to me.

Commercial background services, so long as they do not alter their operations to make copying easier, are fully exempt, and that, too, is similar to the exemption for broadcasters.

Finally, the recording industry will pay mechanical royalties at two different rates, one when records are actually sold and the customer makes a permanent copy, and one in situations where there may be copying of albums by someone who is paying only for the right to listen to the music. This settles a dispute that received a lot of discussion at the June 21 hearing.

By passing this legislation, Congress will open the door to a golden age of digital technology where—as described in a Boston University Law Review article—consumers may never have to set foot in a record store, yet have the ability to choose a musical selection from everything ever recorded without fear that it is out of stock, and be able to copy the album, at any time of the day or night, over a fiber optic cable by using a remote control while sitting in the comfort of their living rooms.

Best of all, all this will be possible without the industrial meltdown that many had feared would put the record companies out of business as a result of the new digital technology or cut off a stream of income to the creative geniuses who are America's composers and song writers.

I am especially pleased that performing artists will also benefit from this legislation. One estimate is that in 1987, performing artists should have received as much as half of the $120 million that is collected worldwide for the public performance of sound recordings; now they stand to recover royalties when recordings of their performances are distributed digitally. I urge strong support for this compromise.

Mrs. SCHROEDER. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from California [Mr. BERMAN] who probably knows more about this issue than I could ever learn.

Mr. BERMAN. Mr. Speaker, I thank the gentlewoman for yielding time to me. I know longer about this bill, I do not know more about this bill. I am happy to voice my strong support of H.R. 1506, the Digital Performance Right in Sound Recordings Act, and I want to congratulate my colleague from California, CARLOS MOORHEAD, because it is on his watch that this long overdue legislation is finally coming to fruition.

The proliferation of new technologies capable of transmitting the fruits of American musical genius directly to consumers with compact disc quality, and what is more, transmitting to Americans what they want to hear when they want to hear it—commands a congressional response. It is not the technology itself which I lament; rather it is the fact that if we fail to act, then American intellectual property is highly likely to lose all meaningful protection.

The constitutional imperative that the Congress protect copyright compels us from time to time to adjust our laws to fit new circumstances. While I have long felt that a performance right in sound recordings is the unfinished business of the omnibus overhaul of our copyright code in 1976, it is the proliferation of new technologies which makes the legislation before us today more important than ever.

Some have criticized the bill for falling short of the ideal, but I have always been loathe to view the best as the enemy of the good. As a member of the Subcommittee on Intellectual Property who proudly represents many of the segments of the music industry with a deep interest in H.R. 1506, I am delighted that this legislation has finally come to fruition, and that it does justice to legitimate concerns which have been raised with us.

This legislation is long overdue, and I commend it to my colleagues for their approval.

Mrs. SCHROEDER. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Maryland [Mr. HOYER].

Mr. HOYER. Mr. Speaker, I thank the gentlewoman for yielding time to me.

Mr. Speaker, I rise in strong support of this legislation. As has been said in this modern age of technological advancement, this type of legislation is needed. Current copyright law cannot adequately address the numerous issues which arise when digital technology is used. Moreover, the number of subscribers obtaining access to digital transmissions is ever-increasing. Therefore, certain modifications to the law are necessary to ensure that recording artists' and record companies' rights are protected. This carefully crafted legislation will ensure that the recording community will not only have the ability to control the distribution of their work, but receive payment for the use of their creative works. From hip-hop to country, reggae to classical, this bill helps to ensure our talented recording artists and recording companies are fairly compensated for public performance of their work. Without this legislation many situations could and, I am sure, would arise where the artists and music companies would not be compensated for their creative work. For many of them, their livelihood depends upon their being appropriately compensated for the use of the songs they have created. It takes much time, energy, and labor to produce material which provides public enjoyment. The creators of these materials deserve to be adequately compensated.

Mr. Speaker, as I am sure some on this floor know, Stephen Foster died essentially a pauper. He died a pauper not because his music was not popular, not because many thousands of people did not play or sing or enjoy his music on a daily, weekly, monthly, and annual basis. It was because there was no system for compensating the genius that was Stephen Foster.

We have geniuses among us today, some of whom are incredibly well compensated, but unfortunately, some of the most creative, perhaps not the most famous or well-known, have not been fairly compensated. This legislation, targeted, is important in a particular area. There are many areas which copyright fails to adequately compensate those who create. Therefore, I think it is incumbent upon us, as has been said, I know, by the chairman and by the ranking member, in an increasingly technological age in which the reproduction of what others have done is much easier, and frankly, the copying and dissemination of that, without any compensation to those who created it, is becoming epidemic, it is important that this Congress act to protect those who create.

Mrs. SCHROEDER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I want to once again urge people to please vote for this. As we see the information highway coming up, this is the information that will go over the highway. If we cannot protect the creators of that information so that they can get compensated when people pull this down and copy it, then there will not be any information on the highway. This is terribly important to the future of the country in the 21st century.

I thank everyone who has worked so hard on this, especially my chairman and especially the industry, who negotiate the long and hard coming to this agreement.

Mr. Speaker, I yield back the balance of my time.

Mr. MOORHEAD. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, this is important legislation. It has been made possible by the leadership of the chairman of our full committee, by the ranking member of our full committee, by the ranking member of our subcommittee, and each and every member of the subcommittee. It is a group endeavor that has made it possible for us to move forward with this important bill in the new superhighway that we are building in the telecommunications industry. I ask every Member to vote ''aye'' on this bill.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California [Mr. MOORHEAD] that the House suspend the rules and pass the bill, H.R. 1506, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

Mr. MOORHEAD. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the Senate bill (S. 227) to amend title 17, United States Code, to provide an exclusive right to perform sound recordings publicly by means of digital transmissions, and for other purposes, and ask for its immediate consideration.

The Clerk red the title of the Senate bill.

The SPEAKER pro tempore (Mr. RIGGS). Is there objection to the request of the gentleman from California?

Mrs. SCHROEDER. Mr. Speaker, reserving the right to object, I do so basically to yield to the gentleman from California [Mr. MOORHEAD] to explain the purpose of his request.

Mr. MOORHEAD. Mr. Speaker, this is the companion Senate bill. This action will enable the bill to go to the President. Both this bill and the former bill basically originated in the House, but the Senate was able to get it passed in their House first, and we want the bills to go immediately to the President of the United States without having to go back to the Senate, so we are incorporating it into the Senate legislation.

Mrs. SCHROEDER. I thank the gentleman from California for his explanation. That is exactly what we want to do. We want to get these bills moving as quickly as possible.

Mr. Speaker, since the gentleman's motion does that, I withdraw my reservation of objection.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

The Clerk read the Senate bill, as follows:

S. 227

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Digital Performance Right in Sound Recordings Act of 1995''.

SEC. 2. EXCLUSIVE RIGHTS IN COPYRIGHTED WORKS.

Section 106 of title 17, United States Code, is amended—

(1) in paragraph (4) by striking ''and'' after the semicolon;

(2) in paragraph (5) by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(6) in the case of sound recordings, to perform the copyrighted work publicly by means of a digital audio transmission.''.

SEC. 3. SCOPE OF EXCLUSIVE RIGHTS IN SOUND RECORDINGS.

Section 114 of title 17, United States Code, is amended—

(1) in subsection (a) by striking ''and (3)'' and inserting ''(3) and (6)'';

(2) in subsection (b) in the first sentence by striking ''phonorecords, or of copies of motion pictures and other audiovisual works,'' and inserting ''phonorecords or copies'';

(3) by striking subsection (d) and inserting:

''(d) LIMITATIONS ON EXCLUSIVE RIGHT.—Notwithstanding the provisions of section 106(6)—

''(1) EXEMPT TRANSMISSIONS AND RETRANSMISSIONS.—The performance of a sound recording publicly by means of a digital audio transmission, other than as a part of an interactive service, is not an infringement of section 106(6) if the performance is part of—

''(A)(i) a nonsubscription transmission other than a retransmission;

''(ii) an initial nonsubscription retransmission made for direct reception by members of the public of a prior or simultaneous incidental transmission that is not made for direct reception by members of the public; or

''(iii) a nonsubscription broadcast transmission;

''(B) a retransmission of a nonsubscription broadcast transmission: *Provided*, That, in the case of a retransmission of a radio station's broadcast transmission—

''(i) the radio station's broadcast transmission is not willfully or repeatedly retransmitted more than a radius of 150 miles from the site of the radio broadcast transmitter, however—

''(I) the 150 mile limitation under this clause shall not apply when a nonsubscription broadcast transmission by a radio station licensed by the Federal Communications Commission is retransmitted on a nonsubscription basis by a terrestrial broadcast station, terrestrial translator, or terrestrial repeater licensed by the Federal Communications Commission; and

''(II) in the case of a subscription retransmission of a nonsubscription broadcast retransmission covered by subclause (I), the 150 mile radius shall be measured from the transmitter site of such broadcast retransmitter;

''(ii) the retransmission is of radio station broadcast transmissions that are—

''(I) obtained by the retransmitter over the air;

''(II) not electronically processed by the retransmitter to deliver separate and discrete signals; and

''(III) retransmitted only within the local communities served by the retransmitter;

''(iii) the radio station's broadcast transmission was being retransmitted to cable systems (as defined in section 111(f)) by a satellite carrier on January 1, 1995, and that retransmission was being retransmitted by cable systems as a separate and discrete signal, and the satellite carrier obtains the radio station's broadcast transmission in an analog format: *Provided*, That the broadcast transmission being retransmitted may embody the programming of no more than one radio station; or

''(iv) the radio station's broadcast transmission is made by a noncommercial educational broadcast station funded on or after January 1, 1995, under section 396(k) of the Communications Act of 1934 (47 U.S.C. 396(k)), consists solely of noncommercial educational and cultural radio programs, and the retransmission, whether or not simultaneous, is a nonsubscription terrestrial broadcast retransmission; or

''(C) a transmission that comes within any of the following categories:

''(i) a prior or simultaneous transmission incidental to an exempt transmission, such as a feed received by and then retransmitted by an exempt transmitter: *Provided*, That such incidental transmissions do not include any subscription transmission directly for reception by members of the public;

''(ii) a transmission within a business establishment, confined to its premises or the immediately surrounding vicinity;

''(iii) a retransmission by any retransmitter, including a multichannel video programming distributor as defined in section 602(12) of the Communications Act of 1934 (47 U.S.C. 522(12)), of a transmission by a transmitter licensed to publicly perform the sound recording as a part of that transmission, if the retransmission is simultaneous with the licensed transmission and authorized by the transmitter; or

''(iv) a transmission to a business establishment for use in the ordinary course of its business: *Provided*, That the business recipient does not retransmit the transmission outside of its premises or the immediately surrounding vicinity, and that the transmission does not exceed the sound recording performance complement. Nothing in this clause shall limit the scope of the exemption in clause (ii).

''(2) SUBSCRIPTION TRANSMISSIONS.—In the case of a subscription transmission not exempt under subsection (d)(1), the performance of a sound recording publicly by means of a digital audio transmission shall be subject to statutory licensing, in accordance with subsection (f) of this section, if—

''(A) the transmission is not part of an interactive service;

''(B) the transmission does not exceed the sound recording performance complement;

''(C) the transmitting entity does not cause to be published by means of an advance program schedule or prior announcement the titles of the specific sound recordings or phonorecords embodying such sound recordings to be transmitted;

''(D) except in the case of transmission to a business establishment, the transmitting entity does not automatically and intentionally cause any device receiving the transmission to switch from one program channel to another; and

''(E) except as provided in section 1002(e) of this title, the transmission of the sound recording is accompanied by the information encoded in that sound recording, if any, by or under the authority of the copyright owner of that sound recording, that identifies the title of the sound recording, the featured recording artist who performs on the sound recording, and related information, including information concerning the underlying musical work and its writer.

''(3) LICENSES FOR TRANSMISSIONS BY INTERACTIVE SERVICES.—

''(A) No interactive service shall be granted an exclusive license under section 106(6) for the performance of a sound recording publicly by means of digital audio transmission for a period in excess of 12 months, except that with respect to an exclusive license granted to an interactive service by a licensor that holds the copyright to 1,000 or fewer sound recordings, the period of such license shall not exceed 24 months: *Provided, however*, That the grantee of such exclusive license shall be ineligible to receive another exclusive license for the performance of that sound recording for a period of 13 months from the expiration of the prior exclusive license.

''(B) The limitation set forth in subparagraph (A) of this paragraph shall not apply if—

''(i) the licensor has granted and there remain in effect licenses under section 106(6) for the public performance of sound recordings by means of digital audio transmission by at least 5 different interactive services: *Provided, however*, That each such license must be for a minimum of 10 percent of the copyrighted sound recordings owned by the licensor that have been licensed to interactive services, but in no event less than 50 sound recordings; or

''(ii) the exclusive license is granted to perform publicly up to 45 seconds of a sound recording and the sole purpose of the performance is to promote the distribution or performance of that sound recording.

''(C) Notwithstanding the grant of an exclusive or nonexclusive license of the right of public performance under section 106(6), an interactive service may not publicly perform a sound recording unless a license has been granted for the public performance of any copyrighted musical work contained in the sound recording: *Provided*, That such license to publicly perform the copyrighted musical work may be granted either by a performing rights society representing the copyright owner or by the copyright owner.

''(D) The performance of a sound recording by means of a retransmission of a digital audio transmission is not an infringement of section 106(6) if—

''(i) the retransmission is of a transmission by an interactive service licensed to publicly perform the sound recording to a particular member of the public as part of that transmission; and

''(ii) the retransmission is simultaneous with the licensed transmission, authorized by the transmitter, and limited to that particular member of the public intended by the interactive service to be the recipient of the transmission.

''(E) For the purposes of this paragraph—

''(i) a 'licensor' shall include the licensing entity and any other entity under any material degree of common ownership, management, or control that owns copyrights in sound recordings; and

''(ii) a 'performing rights society' is an association or corporation that licenses the public performance of nondramatic musical works on behalf of the copyright owner, such as the American Society of Composers, Authors and Publishers, Broadcast Music, Inc., and SESAC, Inc.

''(4) RIGHTS NOT OTHERWISE LIMITED.—

''(A) Except as expressly provided in this section, this section does not limit or impair the exclusive right to perform a sound recording publicly by means of a digital audio transmission under section 106(6).

''(B) Nothing in this section annuls or limits in any way—

''(i) the exclusive right to publicly perform a musical work, including by means of a digital audio transmission, under section 106(4);

''(ii) the exclusive rights in a sound recording or the musical work embodied therein under sections 106(1), 106(2) and 106(3); or

''(iii) any other rights under any other clause of section 106, or remedies available under this title, as such rights or remedies exist either before or after the date of enactment of the Digital Performance Right in Sound Recordings Act of 1995.

''(C) Any limitations in this section on the exclusive right under section 106(6) apply only to the exclusive right under section 106(6) and not to any other exclusive rights under section 106. Nothing in this section shall be construed to annul, limit, impair or otherwise affect in any way the ability of the owner of a copyright in a sound recording to exercise the rights under sections 106(1), 106(2) and 106(3), or to obtain the remedies available under this title pursuant to such rights, as such rights and remedies exist either before or after the date of enactment of the Digital Performance Right in Sound Recordings Act of 1995.''; and

(4) by adding after subsection (d) the following:

''(e) AUTHORITY FOR NEGOTIATIONS.—

''(1) Notwithstanding any provision of the antitrust laws, in negotiating statutory licenses in accordance with subsection (f), any copyright owners of sound recordings and any entities performing sound recordings affected by this section may negotiate and agree upon the royalty rates and license terms and conditions for the performance of such sound recordings and the proportionate division of fees paid among copyright owners, and may designate common agents on a nonexclusive basis to negotiate, agree to, pay, or receive payments.

''(2) For licenses granted under section 106(6), other than statutory licenses, such as for performances by interactive services or performances that exceed the sound recording performance complement—

''(A) copyright owners of sound recordings affected by this section may designate common agents to act on their behalf to grant licenses and receive and remit royalty payments: *Provided*, That each copyright owner shall establish the royalty rates and material license terms and conditions unilaterally, that is, not in agreement, combination, or concert with other copyright owners of sound recordings; and

''(B) entities performing sound recordings affected by this section may designate common agents to act on their behalf to obtain licenses and collect and pay royalty fees: *Provided*, That each entity performing sound recordings shall determine the royalty rates and material license terms and conditions unilaterally, that is, not in agreement, combination, or concert with other entities performing sound recordings.

''(f) LICENSES FOR NONEXEMPT SUBSCRIPTION TRANSMISSIONS.—

''(1) No later than 30 days after the enactment of the Digital Performance Right in Sound Recordings Act of 1995, the Librarian of Congress shall cause notice to be published in the Federal Register of the initiation of voluntary negotiation proceedings for the purpose of determining reasonable terms and rates of royalty payments for the activities specified by subsection (d)(2) of this section during the period beginning on the effective date of such Act and ending on December 31, 2000. Such terms and rates shall distinguish among the different types of digital audio transmission services then in

operation. Any copyright owners of sound recordings or any entities performing sound recordings affected by this section may submit to the Librarian of Congress licenses covering such activities with respect to such sound recordings. The parties to each negotiation proceeding shall bear their own costs.

''(2) In the absence of license agreements negotiated under paragraph (1), during the 60-day period commencing 6 months after publication of the notice specified in paragraph (1), and upon the filing of a petition in accordance with section 803(a)(1), the Librarian of Congress shall, pursuant to chapter 8, convene a copyright arbitration royalty panel to determine and publish in the Federal Register a schedule of rates and terms which, subject to paragraph (3), shall be binding on all copyright owners of sound recordings and entities performing sound recordings. In addition to the objectives set forth in section 801(b)(1), in establishing such rates and terms, the copyright arbitration royalty panel may consider the rates and terms for comparable types of digital audio transmission services and comparable circumstances under voluntary license agreements negotiated as provided in paragraph (1). The Librarian of Congress shall also establish requirements by which copyright owners may receive reasonable notice of the use of their sound recordings under this section, and under which records of such use shall be kept and made available by entities performing sound recordings.

''(3) License agreements voluntarily negotiated at any time between one or more copyright owners of sound recordings and one or more entities performing sound recordings shall be given effect in lieu of any determination by a copyright arbitration royalty panel or decision by the Librarian of Congress.

''(4)(A) Publication of a notice of the initiation of voluntary negotiation proceedings as specified in paragraph (1) shall be repeated, in accordance with regulations that the Librarian of Congress shall prescribe—

''(i) no later than 30 days after a petition is filed by any copyright owners of sound recordings or any entities performing sound recordings affected by this section indicating that a new type of digital audio transmission service on which sound recordings are performed is or is about to become operational; and

''(ii) in the first week of January, 2000 and at 5-year intervals thereafter.

''(B)(i) The procedures specified in paragraph (2) shall be repeated, in accordance with regulations that the Librarian of Congress shall prescribe, upon the filing of a petition in accordance with section 803(a)(1) during a 60-day period commencing—

''(I) six months after publication of a notice of the initiation of voluntary negotiation proceedings under paragraph (1) pursuant to a petition under paragraph (4)(A)(i); or

''(II) on July 1, 2000 and at 5-year intervals thereafter.

''(ii) The procedures specified in paragraph (2) shall be concluded in accordance with section 802.

''(5)(A) Any person who wishes to perform a sound recording publicly by means of a nonexempt subscription transmission under this subsection may do so without infringing the exclusive right of the copyright owner of the sound recording—

''(i) by complying with such notice requirements as the Librarian of Congress shall prescribe by regulation and by paying royalty fees in accordance with this subsection; or

''(ii) if such royalty fees have not been set, by agreeing to pay such royalty fees as shall be determined in accordance with this subsection.

''(B) Any royalty payments in arrears shall be made on or before the twentieth day of the month next succeeding the month in which the royalty fees are set.

''(g) PROCEEDS FROM LICENSING OF SUBSCRIPTION TRANSMISSIONS.—

''(1) Except in the case of a subscription transmission licensed in accordance with subsection (f) of this section—

''(A) a featured recording artist who performs on a sound recording that has been licensed for a subscription transmission shall be entitled to receive payments from the copyright owner of the sound recording in accordance with the terms of the artist's contract; and

''(B) a nonfeatured recording artist who performs on a sound recording that has been licensed for a subscription transmission shall be entitled to receive payments from the copyright owner of the sound recording in accordance with the terms of the nonfeatured recording artist's applicable contract or other applicable agreement.

''(2) The copyright owner of the exclusive right under section 106(6) of this title to publicly perform a sound recording by means of a digital audio transmission shall allocate to recording artists in the following manner its receipts from the statutory licensing of subscription transmission performances of the sound recording in accordance with subsection (f) of this section:

''(A) 2½ percent of the receipts shall be deposited in an escrow account managed by an independent administrator jointly appointed by copyright owners of sound recordings and the American Federation of Musicians (or any successor entity) to be distributed to nonfeatured musicians (whether or not members of the American Federation of Musicians) who have performed on sound recordings.

''(B) 2½ percent of the receipts shall be deposited in an escrow account managed by an independent administrator jointly appointed by copyright owners of sound recordings and the American Federation of Television and Radio Artists (or any successor entity) to be distributed to nonfeatured vocalists (whether or not members of the American Federation of Television and Radio Artists) who have performed on sound recordings.

''(C) 45 percent of the receipts shall be allocated, on a per sound recording basis, to the recording artist or artists featured on such sound recording (or the persons conveying rights in the artists' performance in the sound recordings).

''(h) LICENSING TO AFFILIATES.—

''(1) If the copyright owner of a sound recording licenses an affiliated entity the right to publicly perform a sound recording by means of a digital audio transmission under section 106(6), the copyright owner shall make the licensed sound recording available under section 106(6) on no less favorable terms and conditions to all bona fide entities that offer similar services, except that, if there are material differences in the scope of the requested license with respect to the type of service, the particular sound recordings licensed, the frequency of use, the number of subscribers served, or the duration, then the copyright owner may establish different terms and conditions for such other services.

''(2) The limitation set forth in paragraph (1) of this subsection shall not apply in the case where the copyright owner of a sound recording licenses—

''(A) an interactive service; or

''(B) an entity to perform publicly up to 45 seconds of the sound recording and the sole purpose of the performance is to promote the distribution or performance of that sound recording.

''(i) NO EFFECT ON ROYALTIES FOR UNDERLYING WORKS.—License fees payable for the public performance of sound recordings under section 106(6) shall not be taken into account in any administrative, judicial, or other governmental proceeding to set or adjust the royalties payable to copyright owners of musical works for the public performance of their works. It is the intent of Congress that royalties payable to copyright owners of musical works for the public performance of their works shall not be diminished in any respect as a result of the rights granted by section 106(6).

''(j) DEFINITIONS.—As used in this section, the following terms have the following meanings:

''(1) An 'affiliated entity' is an entity engaging in digital audio transmissions covered by section 106(6), other than an interactive service, in which the licensor has any direct or indirect partnership or any ownership interest amounting to 5 percent or more of the outstanding voting or non-voting stock.

''(2) A 'broadcast' transmission is a transmission made by a terrestrial broadcast station licensed as such by the Federal Communications Commission.

''(3) A 'digital audio transmission' is a digital transmission as defined in section 101, that embodies the transmission of a sound recording. This term does not include the transmission of any audiovisual work.

''(4) An 'interactive service' is one that enables a member of the public to receive, on request, a transmission of a particular sound recording chosen by or on behalf of the recipient. The ability of individuals to request that particular sound recordings be performed for reception by the public at large does not make a service interactive. If an entity offers both interactive and non-interactive services (either concurrently or at different times), the non-interactive component shall not be treated as part of an interactive service.

''(5) A 'nonsubscription' transmission is any transmission that is not a subscription transmission.

''(6) A 'retransmission' is a further transmission of an initial transmission, and includes any further retransmission of the same transmission. Except as provided in this section, a transmission qualifies as a 'retransmission' only if it is simultaneous with the initial transmission. Nothing in this definition shall be construed to exempt a transmission that fails to satisfy a separate element required to qualify for an exemption under section 114(d)(1).

''(7) The 'sound recording performance complement' is the transmission during any 3-hour period, on a particular channel used by a transmitting entity, of no more than—

''(A) 3 different selections of sound recordings from any one phonorecord lawfully distributed for public performance or sale in the United States, if no more than 2 such selections are transmitted consecutively; or

''(B) 4 different selections of sound recordings

''(i) by the same featured recording artist; or

''(ii) from any set or compilation of phonorecords lawfully distributed together as a unit for public performance or sale in the United States,

if no more than three such selections are transmitted consecutively:

Provided, That the transmission of selections in excess of the numerical limits provided for in clauses (A) and (B) from multiple phonorecords shall nonetheless qualify as a sound recording performance complement if the programming of the multiple phonorecords was not willfully intended to

avoid the numerical limitations prescribed in such clauses.

''(8) A 'subscription' transmission is a transmission that is controlled and limited to particular recipients, and for which consideration is required to be paid or otherwise given by or on behalf of the recipient to receive the transmission or a package of transmissions including the transmission.

''(9) A 'transmission' includes both an initial transmission and a retransmission.''.

SEC. 4. MECHANICAL ROYALTIES IN DIGITAL PHONORECORD DELIVERIES.

Section 115 of title 17, United States Code, is amended—

(1) in subsection (a)(1)—

(A) in the first sentence by striking out ''any other person'' and inserting in lieu thereof ''any other person, including those who make phonorecords or digital phonorecord deliveries,''; and

(B) in the second sentence by inserting before the period '', including by means of a digital phonorecord delivery'';

(2) in subsection (c)(2) in the second sentence by inserting ''and other than as provided in paragraph (3),'' after ''For this purpose,'';

(3) by redesignating paragraphs (3), (4), and (5) of subsection (c) as paragraphs (4), (5), and (6), respectively, and by inserting after paragraph (2) the following new paragraph:

''(3)(A) A compulsory license under this section includes the right of the compulsory licensee to distribute or authorize the distribution of a phonorecord of a nondramatic musical work by means of a digital transmission which constitutes a digital phonorecord delivery, regardless of whether the digital transmission is also a public performance of the sound recording under section 106(6) of this title or of any nondramatic musical work embodied therein under section 106(4) of this title. For every digital phonorecord delivery by or under the authority of the compulsory licensee—

''(i) on or before December 31, 1997, the royalty payable by the compulsory licensee shall be the royalty prescribed under paragraph (2) and chapter 8 of this title; and

''(ii) on or after January 1, 1998, the royalty payable by the compulsory licensee shall be the royalty prescribed under subparagraphs (B) through (F) and chapter 8 of this title.

''(B) Notwithstanding any provision of the antitrust laws, any copyright owners of nondramatic musical works and any persons entitled to obtain a compulsory license under subsection (a)(1) may negotiate and agree upon the terms and rates of royalty payments under this paragraph and the proportionate division of fees paid among copyright owners, and may designate common agents to negotiate, agree to, pay or receive such royalty payments. Such authority to negotiate the terms and rates of royalty payments includes, but is not limited to, the authority to negotiate the year during which the royalty rates prescribed under subparagraphs (B) through (F) and chapter 8 of this title shall next be determined.

''(C) During the period of June 30, 1996, through December 31, 1996, the Librarian of Congress shall cause notice to be published in the Federal Register of the initiation of voluntary negotiation proceedings for the purpose of determining reasonable terms and rates of royalty payments for the activities specified by subparagraph (A) during the period beginning January 1, 1998, and ending on the effective date of any new terms and rates established pursuant to subparagraph (C), (D) or (F), or such other date (regarding digital phonorecord deliveries) as the parties may agree. Such terms and rates shall distinguish between (i) digital phonorecord deliveries where the reproduction or distribution of a phonorecord is incidental to the transmission which constitutes the digital phonorecord delivery, and (ii) digital phonorecord deliveries in general. Any copyright owners of nondramatic musical works and any persons entitled to obtain a compulsory license under subsection (a)(1) may submit to the Librarian of Congress licenses covering such activities. The parties to each negotiation proceeding shall bear their own costs.

''(D) In the absence of license agreements negotiated under subparagraphs (B) and (C), upon the filing of a petition in accordance with section 803(a)(1), the Librarian of Congress shall, pursuant to chapter 8, convene a copyright arbitration royalty panel to determine and publish in the Federal Register a schedule of rates and terms which, subject to subparagraph (E), shall be binding on all copyright owners of nondramatic musical works and persons entitled to obtain a compulsory license under subsection (a)(1) during the period beginning January 1, 1998, and ending on the effective date of any new terms and rates established pursuant to subparagraph (C), (D) or (F), or such other date (regarding digital phonorecord deliveries) as may be determined pursuant to subparagraphs (B) and (C). Such terms and rates shall distinguish between (i) digital phonorecord deliveries where the reproduction or distribution of a phonorecord is incidental to the transmission which constitutes the digital phonorecord delivery, and (ii) digital phonorecord deliveries in general. In addition to the objectives set forth in section 801(b)(1), in establishing such rates and terms, the copyright arbitration royalty panel may consider rates and terms under voluntary license agreements negotiated as provided in subparagraphs (B) and (C). The royalty rates payable for a compulsory license for a digital phonorecord delivery under this section shall be established de novo and no precedential effect shall be given to the amount of the royalty payable by a compulsory licensee for digital phonorecord deliveries on or before December 31, 1997. The Librarian of Congress shall also establish requirements by which copyright owners may receive reasonable notice of the use of their works under this section, and under which records of such use shall be kept and made available by persons making digital phonorecord deliveries.

''(E)(i) License agreements voluntarily negotiated at any time between one or more copyright owners of nondramatic musical works and one or more persons entitled to obtain a compulsory license under subsection (a)(1) shall be given effect in lieu of any determination by the Librarian of Congress. Subject to clause (ii), the royalty rates determined pursuant to subparagraph (C), (D) or (F) shall be given effect in lieu of any contrary royalty rates specified in a contract pursuant to which a recording artist who is the author of a nondramatic musical work grants a license under that person's exclusive rights in the musical work under sections 106(1) and (3) or commits another person to grant a license in that musical work under sections 106(1) and (3), to a person desiring to fix in a tangible medium of expression a sound recording embodying the musical work.

''(ii) The second sentence of clause (i) shall not apply to—

''(I) a contract entered into on or before June 22, 1995, and not modified thereafter for the purpose of reducing the royalty rates determined pursuant to subparagraph (C), (D) or (F) or of increasing the number of musical works within the scope of the contract covered by the reduced rates, except if a contract entered into on or before June 22, 1995, is modified thereafter for the purpose of increasing the number of musical works within the scope of the contract, any contrary royalty rates specified in the contract shall be given effect in lieu of royalty rates determined pursuant to subparagraph (C), (D) or (F) for the number of musical works within the scope of the contract as of June 22, 1995; and

''(II) a contract entered into after the date that the sound recording is fixed in a tangible medium of expression substantially in a form intended for commercial release, if at the time the contract is entered into, the recording artist retains the right to grant licenses as to the musical work under sections 106(1) and 106(3).

''(F) The procedures specified in subparagraphs (C) and (D) shall be repeated and concluded, in accordance with regulations that the Librarian of Congress shall prescribe, in each fifth calendar year after 1997, except to the extent that different years for the repeating and concluding of such proceedings may be determined in accordance with subparagraphs (B) and (C).

''(G) Except as provided in section 1002(e) of this title, a digital phonorecord delivery licensed under this paragraph shall be accompanied by the information encoded in the sound recording, if any, by or under the authority of the copyright owner of that sound recording, that identifies the title of the sound recording, the featured recording artist who performs on the sound recording, and related information, including information concerning the underlying musical work and its writer.

''(H)(i) A digital phonorecord delivery of a sound recording is actionable as an act of infringement under section 501, and is fully subject to the remedies provided by sections 502 through 506 and section 509, unless—

''(I) the digital phonorecord delivery has been authorized by the copyright owner of the sound recording; and

''(II) the owner of the copyright in the sound recording or the entity making the digital phonorecord delivery has obtained a compulsory license under this section or has otherwise been authorized by the copyright owner of the musical work to distribute or authorize the distribution, by means of a digital phonorecord delivery, of each musical work embodied in the sound recording.

''(ii) Any cause of action under this subparagraph shall be in addition to those available to the owner of the copyright in the nondramatic musical work under subsection (c)(6) and section 106(4) and the owner of the copyright in the sound recording under section 106(6).

''(I) The liability of the copyright owner of a sound recording for infringement of the copyright in a nondramatic musical work embodied in the sound recording shall be determined in accordance with applicable law, except that the owner of a copyright in a sound recording shall not be liable for a digital phonorecord delivery by a third party if the owner of the copyright in the sound recording does not license the distribution of a phonorecord of the nondramatic musical work.

''(J) Nothing in section 1008 shall be construed to prevent the exercise of the rights and remedies allowed by this paragraph, paragraph (6), and chapter 5 in the event of a digital phonorecord delivery, except that no action alleging infringement of copyright may be brought under this title against a manufacturer, importer or distributor of a digital audio recording device, a digital audio recording medium, an analog recording device, or an analog recording medium, or against a consumer, based on the actions described in such section.

''(K) Nothing in this section annuls or limits (i) the exclusive right to publicly perform

a sound recording or the musical work embodied therein, including by means of a digital transmission, under sections 106(4) and 106(6), (ii) except for compulsory licensing under the conditions specified by this section, the exclusive rights to reproduce and distribute the sound recording and the musical work embodied therein under sections 106(1) and 106(3), including by means of a digital phonorecord delivery, or (iii) any other rights under any other provision of section 106, or remedies available under this title, as such rights or remedies exist either before or after the date of enactment of the Digital Performance Right in Sound Recordings Act of 1995.

''(L) The provisions of this section concerning digital phonorecord deliveries shall not apply to any exempt transmissions or retransmissions under section 114(d)(1). The exemptions created in section 114(d)(1) do not expand or reduce the rights of copyright owners under section 106(1) through (5) with respect to such transmissions and retransmissions.''; and

(5) by adding after subsection (c) the following:

''(d) DEFINITION.—As used in this section, the following term has the following meaning: A 'digital phonorecord delivery' is each individual delivery of a phonorecord by digital transmission of a sound recording which results in a specifically identifiable reproduction by or for any transmission recipient of a phonorecord of that sound recording, regardless of whether the digital transmission is also a public performance of the sound recording or any nondramatic musical work embodied therein. A digital phonorecord delivery does not result from a real-time, noninteractive subscription transmission of a sound recording where no reproduction of the sound recording or the musical work embodied therein is made from the inception of the transmission through to its receipt by the transmission recipient in order to make the sound recording audible.''.

SEC. 5. CONFORMING AMENDMENTS.

(a) DEFINITIONS.—Section 101 of title 17, United States Code, is amended by inserting after the definition of ''device'', ''machine'', or ''process'' the following:

''A 'digital transmission' is a transmission in whole or in part in a digital or other nonanalog format.''.

(b) LIMITATIONS ON EXCLUSIVE RIGHTS: SECONDARY TRANSMISSIONS.—Section 111(c)(1) of title 17, United States Code, is amended in the first sentence by inserting ''and section 114(d)'' after ''of this subsection''.

(c) LIMITATIONS ON EXCLUSIVE RIGHTS: SECONDARY TRANSMISSIONS OF SUPERSTATIONS AND NETWORK STATIONS FOR PRIVATE HOME VIEWING.—

(1) Section 119(a)(1) of title 17, United States Code, is amended in the first sentence by inserting ''and section 114(d)'' after ''of this subsection''.

(2) Section 119(a)(2)(A) of title 17, United States Code, is amended in the first sentence by inserting ''and section 114(d)'' after ''of this subsection''.

(d) COPYRIGHT ARBITRATION ROYALTY PANELS.—

(1) Section 801(b)(1) of title 17, United States Code, is amended in the first and second sentences by striking ''115'' each place it appears and inserting ''114, 115,''.

(2) Section 802(c) of title 17, United States Code, is amended in the third sentence by striking ''section 111, 116, or 119,'' and inserting ''section 111, 114, 116, or 119, any person entitled to a compulsory license under section 114(d), any person entitled to a compulsory license under section 115,''.

(3) Section 802(g) of title 17, United States Code, is amended in the third sentence by inserting ''114,'' after ''111,''.

(4) Section 802(h)(2) of title 17, United States Code, is amended by inserting ''114,'' after ''111,''.

(5) Section 803(a)(1) of title 17, United States Code, is amended in the first sentence by striking ''115'' and inserting ''114, 115'' and by striking ''and (4)'' and inserting ''(4) and (5)''.

(6) Section 803(a)(3) of title 17, United States Code, is amended by inserting before the period ''or as prescribed in section 115(c)(3)(D)''.

(7) Section 803(a) of title 17, United States Code, is amended by inserting after paragraph (4) the following new paragraph:

''(5) With respect to proceedings under section 801(b)(1) concerning the determination of reasonable terms and rates of royalty payments as provided in section 114, the Librarian of Congress shall proceed when and as provided by that section.''.

SEC. 6. EFFECTIVE DATE.

This Act and the amendments made by this Act shall take effect 3 months after the date of enactment of this Act, except that the provisions of sections 114(e) and 114(f) of title 17, United States Code (as added by section 3 of this Act) shall take effect immediately upon the date of enactment of this Act.

The Senate bill was ordered to be read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

Similar House bills (H.R. 1506) and (H.R. 587) were laid on the table.

GENERAL LEAVE

Mr. MOORHEAD. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks on the bills just considered.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

PROVIDING FOR DISTRIBUTION OF USIA FILM ''FRAGILE RING OF LIFE''

Mr. SMITH of New Jersey. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2070) to provide for the distribution within the United States of the U.S. Information Agency film entitled ''Fragile Ring of Life.''

The Clerk read as follows:

H.R. 2070

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. DISTRIBUTION WITHIN THE UNITED STATES OF THE UNITED STATES INFORMATION AGENCY FILM ENTITLED ''FRAGILE RING OF LIFE''.

Notwithstanding section 208 of the Foreign Relations Authorization Act, Fiscal Years 1986 and 1987 (22 U.S.C. 1461–1(a)) and the second sentence of section 501 of the United States Information and Education Exchange Act of 1948 (22 U.S.C. 1461)—

(1) the Director of the United States Information Agency shall make available to the Archivist of the United States a master copy of the film entitled ''Fragile Ring of Life''; and

(2) upon evidence that necessary United States rights and licenses have been secured and paid for by the person seeking domestic release of the film, the Archivist shall—

(A) reimburse the Director for any expenses of the Agency in making that master copy available;

(B) deposit that film in the National Archives of the United States; and

(C) make copies of that film available for purchase and public viewing within the United States.

Any reimbursement to the Director pursuant to this section shall be credited to the applicable appropriation of the United States Information Agency.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey [Mr. SMITH] and the gentleman from Virginia [Mr. MORAN] each will be recognized for 20 minutes.

The Chair recognizes the gentleman from New Jersey [Mr. SMITH].

☐ 1545

Mr. Speaker, I yield myself such time as I may consume.

(Mr. SMITH of New Jersey asked and was given permission to revise and extend his remarks.)

Mr. SMITH of New Jersey. Mr. Speaker, I rise in support of H.R. 2070 as introduced by our colleague, Mr. MORAN. This legislation authorizes the distribution within the United States of a specific film, ''The Fragile Ring of Life'' produced by the U.S. Information Agency.

This legislation is necessary because section 501 of the Smith Mundt Act of 1948 prevents the release within the United States of products commissioned by the U.S. Information Agency for 12 years.

The intent of the Smith Mundt Act is to prevent the executive branch from using the U.S. Information Agency as a political tool within the United States. While this is a reasonable objective, over the years Congress has approved the early release of several films and videotape programs through legislative action. The decision to waive the Smith Mundt Act restriction on domestic dissemination is usually based on finding the material offers worthwhile educational or cultural information of interest or value to American citizens.

The ''Fragile Ring of Life'' does meet these standards. The film discusses programs operating around the world that are focused on protecting sea life and coral reefs. In addition, it provides a useful summary of various efforts to establish environmentally sound practices within countries that rely upon the sea for food, commerce, or tourism.

I urge support for H.R. 2070 so that this film may be made available to domestic viewers.

Mr. Speaker, I reserve the balance of my time.

Mr. MORAN. Mr. Speaker, I yield myself such time as I may consume.

This is a very simple, straightforward, noncontroversial bill. It simply allows the film that the U.S. Information Agency sponsored, the ''Fragile Ring of Fire,'' to be distributed within the United States.

If it were not for this legislation, this film could not be shown for another 12 years, because, as the gentleman from

New Jersey [Mr. SMITH] said, the Smith-Mundt Act of 1948, and I gather that was no relation to the gentleman from New Jersey [Mr. SMITH], it was another Mr. Smith, but in 1948 to prevent the executive branch from using the U.S. Information Agency as a political tool, and it said that the film has to be around for 12 years before it can be shown initially in the United States.

We have passed any number of other pieces of legislation because of this restrictive law. The Thomas Jefferson papers show, which commemorated the 250th anniversary of Thomas Jefferson's birth; we had a documentary about crimes against humanity regarding the conflict in Yugoslavia; we had a film called ''The Long Way Home,'' about the humanitarian crisis in Afghanistan; a tribute to Mickey Leland; photographs of military operations-related activities in the Republic of Vietnam for the purpose of developing and publishing military histories. All of these films served an important purpose, but they all had to get this kind of specific legislative authority before they could be shown in the United States.

The ''Fragile Ring of Fire'' is important because it will contribute to scholarly efforts and public awareness of these undersea issues. There are a number of private sector efforts going on to protect the world's coral reefs by revealing the incredible beauty and productivity of coral reefs in generating food, income, and employment to communities around the world. This film shows some stark examples of the environmental degradation that has occurred and highlights the most successful reef conservation programs. The filmmakers went all the way around the Florida keys, Sri Lanka, Jamaica, Egypt, Israel, Jordan, and shot some stunning underwater scenes in all of these locations. It is just so ironic that it cannot be shown in the United States.

Coral reefs are one of the most diverse and important of all natural ecosystems. They are considered the rain forests of the ocean. They are located within eight States, U.S. States and territories, and the third largest reef in the world is located next to the Florida keys. It spans 150 miles from the south of Miami to the Gulf of Mexico, and over 6 million tourists every year visit the keys to boat, fish, and snorkel and scuba dive and see more than 6,000 species of plants, fish, and invertebrates.

Because the keys are so important, not only commercially but because of protein they provide, any number of environmental contributions that coral reefs make, it is disturbing that 10 percent of the reefs have been lost already, and scientists estimate another 20 to 30 percent could be lost over the next 15 years.

That is why this is important to be shown. The State Department has a coral reef initiative that brings seven countries together to more effectively manage coral reef ecosystems.

The Department of State already has a long list of organizations that want to participate in this within the United States, schools, museums, environmental groups, and they need to be able to show this film.

I cannot imagine any reason why all of the Members would not want them to be able to show this film, and, in fact, many of the Members may want to make it available to their school systems.

I do want to express my appreciation to the gentleman from Indiana [Mr. HAMILTON], the ranking Democrat on the full committee, and the gentleman from New York [Mr. GILMAN], the chairman of the Committee on International Relations, in moving this through the committee, and lastly, I want to put in a plug in recognition to the superb staff of the Committee on International Relations, Beth Ford and Kristen Gilley. They have done a terrific job, as well as Kris King, on my staff, who has followed this for months and made sure it got legislated, as well as putting all of these thoughts together.

Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. SMITH of New Jersey. Mr. Speaker, I yield myself such time as I may consume.

I do thank the gentleman for his kind words. It is a good bill.

Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. RIGGS). The question is on the motion offered by the gentleman from New Jersey [Mr. SMITH] that the House suspend the rules and pass the bill, H.R. 2070.

The question was taken.

Mr. SMITH of New Jersey. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Pursuant to clause 5 of rule 1 and the Chair's prior announcement, further proceedings on this motion will be postponed.

The point of no quorum is considered withdrawn.

GENERAL LEAVE

Mr. SMITH of New Jersey. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 2070, the bill just considered.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

THE FALL RIVER VISITOR CENTER ACT OF 1995

Mr. ALLARD. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 629) to authorize the Secretary of the Interior to participate in the operation of certain visitor facilities associated with, but outside the boundaries of, Rocky Mountain National Park in the State of Colorado.

The Clerk read as follows:

H.R. 629

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as ''The Fall River Visitor Center Act of 1995''.

SEC. 2. EXPENDITURE OF FUNDS OUTSIDE AUTHORIZED BOUNDARY OF ROCKY MOUNTAIN NATIONAL PARK.

(a) VISITOR CENTER.—The Secretary of the Interior is authorized to collect and expend donated funds and expend appropriated funds for the operation and maintenance of a visitor center to be constructed for visitors to and administration of Rocky Mountain National Park with private funds on the privately owned lands described in subsection (b).

(b) DESCRIPTION OF PARCELS OF LAND.—The lands referred to in subsection (a) are described as follows:

Being land owned by H.W. Stewart, Inc., and more particularly described as follows:

Beginning at the southwest corner of the north one-half of section 16, township 5 north, range 73 west of the sixth principal meridian, Colorado; thence south eighty-seven degrees six minutes east, eight hundred and fifty-four feet; thence north two degrees west, three hundred and forty-six and one-tenth feet to the south boundary of the right-of-way of U.S. Highway 34; thence northwesterly along said south boundary nine hundred and sixty feet to the west line of said section 16; thence south along the west line of said section 16 to the point of beginning.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Colorado [Mr. ALLARD] will be recognized for 20 minutes, and the gentleman from California [Mr. MILLER] will be recognized for 20 minutes.

The Chair recognizes the gentleman from Colorado [Mr. ALLARD].

Mr. ALLARD. Mr. Speaker, I yield myself such time as I may consume.

(Mr. ALLARD asked and was given permission to revise and extend his remarks.)

Mr. ALLARD. Mr. Speaker, this bill was brought before the Natural Resources Committee's Subcommittee on National Parks, Forests and Lands last year but could not be moved forward because of concerns raised during the planning process. I am happy to report that all of those concerns have now been addressed and the proposal was approved by the Larimer County Planning Commission in January. The Larimer County Commissioners approved the plan in March. Finally, last year the Park Service suggested a technical change to the bill language which was incorporated into this year's bill. This legislation is a fine example of how the Government and private sector can work together and I appreciate the opportunity to bring the bill before the House today.

This bill is a simple piece of legislation, but one that will have a noticeable impact on the people who enjoy

the beauty and recreational opportunities at Rocky Mountain National Park. The legislation simply allows the National Park Service to enter into a cooperative agreement to operate and maintain a visitor center at the Fall River entrance to the park. The bill gives the Secretary of Interior the authority to collect and expend donated funds and expend appropriated funds for the operation and maintenance of the visitor center, which will be located outside the boundary of Rocky Mountain National Park. I introduced this legislation on January 23, 1995, and Senator HANK BROWN introduced a companion bill in the Senate on February 7, 1995.

Mr. Speaker, this is a unique project that deserves our attention and utmost consideration. For some time now there has been tremendous support to construct a visitor center at the Fall River entrance of Rocky Mountain National Park. With 1 million tourists entering the park at this entrance every year, the need to provide an orientation and interpretation facility is well known. As you can imagine, park visitation through this entrance is expected to increase in coming years, not decrease.

The need and desire for a visitor center at the Fall River site is not new. It was first documented in a plan prepared by the Park Service in 1976, and again in 1989. However, due to budget pressures and fiscal constraints this plan was never set into motion.

It was not until early 1993 that the prospect for constructing a new visitor center actually became possible. It was then that Mr. Bill Carle, owner of H.W. Stewart, Inc., approached the park superintendent with his idea for the creation of the Fall River Visitor Center.

Under the Fall River proposal, the visitor center would be built with private funds on land that will remain privately owned. The National Park Service, with assistance from the Shirley S. Scrogin Charitable Trust, the Rocky Mountain Nature Association, and the Rocky Mountain National Park Associates, would operate and maintain the visitor center. The park will use existing staff and operational funds to operate the center. Besides covering the cost of construction, the Shirley S. Scrogin Trust would also contribute funds annually for the maintenance of the center. The Rocky Mountain Nature Association, a friends of the park group, will provide a book sales operation and staff support for the center. Revenue generated from book sales will assist in defraying costs associated with the visitor center's operation. The Rocky Mountain National Park Associates, another friends of the park group, will assume the financial expenses for exhibit planning, design, and construction.

Mr. Speaker, as a member of the House Budget Committee, I can attest to the difficulty the committee faces all the time when trying to stay within the budget requirements and utilize taxpayer's money judiciously. We are constantly looking for ways to reduce spending, cut duplicative programs, and put Congress on a path toward fiscal responsibility. I believe H.R. 629 fulfills these goals and will yield savings for the Federal Government, as well as produce rewards.

I am sure you understand the financial constraints that face our National Park Service today. Due to the scarcity of dollars, it is doubtful that Rocky Mountain National Park will be appropriated—at any time in the near future—the funds necessary to construct a new visitor center from start to finish. Thus, the opportunity before us today is unique and one that we must not let fall through the cracks. The idea of a private-public partnership is one that I know many in Congress and the administration support. It makes sense from both a fiscal and practical point of view.

As I have tried to note, the benefits of this proposal are numerous: Visitors who come to Rocky Mountain National Park can enjoy the new visitor center; the Park Service will be allowed to collect fees at the Fall River entrance; and the developer will be able to reopen his businesses that were lost during a fire.

In summary, this proposal brings together the best qualities in both the public and private sectors. It combines the strengths and visions of both entities and provides a blueprint for similar joint ventures in the future. Whenever Congress has the opportunity to provide the public with the services it needs, while at the same time saving taxpayer's money, it must seize that opportunity. By passing this legislation today, we will have taken the first important step on the road to similar public-private partnerships in the future.

Mr. Speaker, I reserve the balance of my time.

Mr. MILLER of California. Mr. Speaker, I yield myself such time as I may consume.

(Mr. MILLER of California asked and was given permission to revise and extend his remarks.)

Mr. MILLER of California. Mr. Speaker, the gentleman from Colorado has quite accurately reflected the content of H.R. 629. It had bipartisan support coming out of the committee. We continue to support it.

Mr. Speaker, if enacted this legislation would allow the National Park Service to enter into cooperative agreements with private and not-for-profit entities in order to construct, maintain, and operate a visitors center on private land outside park boundaries of the Rocky Mountain National Park. This would be the first ever such public/private venture to address a park need.

Rocky Mountain National Park is the No. 1 tourist attraction in the State of Colorado with an annual visitation of almost 3 million people. Currently, almost 1 million of those visitors enter the park through the Fall River entrance and do so without benefit of a National Park Service facility. Such a facility would greatly enhance the stay of the park visitor by providing information on camping, trails, park rules, safety tips, and historical data on the terrain and wildlife.

There has been much local input on this proposal and I believe all parties have addressed the foreseeable issues. I look forward to the outcome of this joint venture as I believe it may be a model for similar agreements in the future.

Mr. YOUNG of Alaska. Mr. Speaker, H.R. 629 is a noncontroversial bill which will authorize the National Park Service to spend Federal funds to operate a new visitor center. The center will be developed with private funds and located on private lands just outside the entrance of Rocky Mountain National Park. The bill is consistent with Park Service plans, supported by the administration and will be funded from existing funds.

Mr. Speaker, Rocky Mountain National Park is the No. 1 tourist attraction in the State of Colorado and a new visitor center will serve to educate the visitors about the park and its resources, while encouraging a partnership with the private sector. I urge my colleagues to support this bill.

Mr. MILLER of California. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. ALLARD. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Colorado [Mr. ALLARD] that the House suspend the rules and pass the bill, H.R. 629.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. ALLARD. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 629, the bill just passed.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Colorado?

There was no objection.

WATER RESOURCES RESEARCH ACT AMENDMENTS OF 1995

Mr. DOOLITTLE. Mr. Speaker, I move to suspend spend the rules and pass the bill (H.R. 1743) to amend the Water Resources Research Act of 1984 to extend the authorizations of appropriations through fiscal year 2000, and for other purposes, as amended.

The Clerk read as follows:

H.R. 1743

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. FINDINGS.

Section 102 of the Water Resources Research Act of 1984 (42 U.S.C. 10301) is amended—

(1) in paragraph (2), by inserting ‘‘, productivity of natural resources and agricultural systems,’’ after ‘‘environmental quality’’;

(2) by striking out ‘‘and’’ at the end of paragraph (6);

(3) by striking out the period at the end of paragraph (7) and inserting ‘‘; and’’; and

(4) by adding at the end the following:

‘‘(8) long-term planning and policy development are essential to assuring the availability of an abundant supply of high quality water for domestic and other uses; and

‘‘(9) the States must have the research and problem-solving capacity necessary to effectively manage their water resources.’’.

SEC. 2. PURPOSE.

Section 103 of the Water Resources Research Act of 1984 (42 U.S.C. 10302) is amended—

(1) by striking ‘‘and’’ at the end of paragraph (5);

(2) by striking the period at the end of paragraph (6) and inserting ‘‘; and’’; and

(3) by adding at the end the following:

‘‘(7) encourage long-term planning and research to meet future water management, quality, and supply challenges.’’.

SEC. 3. GRANTS; MATCHING FUNDS.

Section 104(c) of the Water Resources Research Act of 1984 (42 U.S.C. 10303(c)) is amended by striking ‘‘one non-Federal dollar’’ and all that follows through ‘‘thereafter’’ and inserting ‘‘two non-Federal dollars for every Federal dollar’’.

SEC. 4. GENERAL AUTHORIZATIONS OF APPROPRIATIONS.

Section 104(f)(1) of the Water Resources Research Act of 1984 (42 U.S.C. 10303(f)(1)) is amended by striking ‘‘of $10,000,000 for each of the fiscal years ending September 30, 1989, through September 30, 1995,’’ and inserting ‘‘of $5,000,000 for fiscal year 1996, $7,000,000 for fiscal years 1997 and 1998, and $9,000,000 for fiscal years 1999 and 2000’’.

SEC. 5. COORDINATION.

Section 104 of the Water Resources Research Act of 1984 (42 U.S.C. 10303) is amended by adding at the end the following:

‘‘(h)(1) To carry out provisions of this Act, the Secretary—

‘‘(A) shall encourage other Federal departments, agencies (including agencies within the Department of the Interior), and instrumentalities to use and take advantage of the expertise and capabilities which are available through the institutes established by this section, on a cooperative or other basis;

‘‘(B) shall encourage cooperation and coordination with other Federal programs concerned with water resources problems and issues;

‘‘(C) may enter into contracts, cooperative agreements, and other transactions without regard to section 3709 of the Revised Statutes (41 U.S.C. 5);

‘‘(D) may accept funds from other Federal departments, agencies (including agencies within the Department of the Interior), and instrumentalities to pay for and add to grants made, and contracts entered into, by the Secretary;

‘‘(E) may promulgate such rules and regulations as he deems appropriate; and

‘‘(F) may support a program of internships for qualified individuals at the undergraduate and graduate level to carry out the educational and training objectives of this Act.

‘‘(2) The Secretary shall report to Congress annually on coordination efforts with other Federal departments, agencies, and instrumentalities under paragraph (1).

‘‘(3) Nothing in this Act shall preempt the rights and authorities of any State with respect to its water resources or management of those resources.’’.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from California [Mr. DOOLITTLE] will be recognized for 20 minutes, and the gentleman from California [Mr. MILLER] will be recognized for 20 minutes.

The Chair recognizes the gentleman from California [Mr. DOOLITTLE].

Mr. DOOLITTLE. Mr. Speaker, I yield myself such time as I may consume.

(Mr. DOOLITTLE asked and was given permission to revise and extend his remarks.)

Mr. DOOLITTLE. Mr. Speaker, the primary intent of H.R. 1743 is to extend the authorization for the State Water Resources Research Institutes. Through the act, the institutes have established a Federal/State partnership in water resources, education, and information transfer. There are 54 of these institutes located at the land grant university in each of the 50 States and several of the territories. These institutes are a primary link between the academic community, the water-related personnel in Federal and State government, and the private sector. The institutes provide a mechanism for promoting State, regional, and national coordination of water resources research and training. They also serve as a network to facilitate research coordination and information transfer. Their programs are coordinated with the general guidance of the Secretary of the Interior.

This is a popular program because research from the water institutes is often directed at finding solutions to water problems that have local and regional relevance. Research results from the program are often applied to real-world problems in water management.

H.R. 1743 would expand the act’s findings and focus on the need for long-term planning and policy development, support for States in water resources management, and maintaining productivity of natural resources and agricultural systems.

H.R. 1743 sets forth new requirements for the Interior Department to coordinate and cooperate with other departments and agencies of the Federal Government on water resources problems and requires an annual report on these efforts to Congress.

Mr. Speaker, I reserve the balance of my time.

Mr. MILLER of California. Mr. Speaker, I yield myself such time as I may consume.

(Mr. MILLER of California asked and was given permission to revise and extend his remarks.)

Mr. MILLER of California. Mr. Speaker, again, on this legislation, H.R. 1743, the Water Resources Research Act reauthorization, the gentleman from California [Mr. DOOLITTLE], the subcommittee Chair, has accurately described the bill, and it has bipartisan support, and I believe bipartisan support both here and in the Senate.

We would urge the passage of the bill.

Mr. Speaker, I rise in support of H.R. 1743, a bill to amend the Water Resources Research Act of 1984.

This legislation extends the authorization of this important program for 5 years and also provides new flexibility for the program. New cost-sharing requirements are also specified in this legislation.

The Water Research Program has provided us with extraordinary benefits for 30 years. We now have water research institutes in every State, as well as in the Virgin Islands, Guam, the District of Columbia, and Puerto Rico. The program supports our educational institutions by training engineers and scientists skilled in all aspects of water research and management.

With help from the Water Research Program and the State research institutes, we have improved our capability to manage floods and to plan community growth to avoid flood damages. We have improved our ability to clean up chemical contamination of our water supplies. And we have trained hundreds of scientists, technicians, and engineers to help us solve complex water management problems.

The Water Resources Research Program authorized by H.R. 1743 is a cost-effective and inexpensive program. Costs of operating the program are shared with non-Federal interests. The program provides valuable research that is useful to local and State water managers throughout the Nation. The water research program has given us years of service and deserves our continued support.

I urge my colleagues to support H.R. 1743.

Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. DOOLITTLE. Mr. Speaker, I yield myself such time as I may consume.

I would like to thank the gentleman from California [Mr. MILLER] for his support on this.

Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California [Mr. DOOLITTLE] that the House suspend the rules and pass the bill, H.R. 1743, as amended.

The question was taken; and (two-thirds having voted in favor thereof), the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. DOOLITTLE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 1743, the bill just passed.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 2066

Mr. MILLER of California. Mr. Speaker, I ask unanimous consent that my name be removed from the list of cosponsors of H.R. 2066.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

□ 1600

COLLECTION OF FEES FOR TRIPLOID GRASS CARP CERTIFICATION INSPECTIONS

Mr. SAXTON. Mr. Speaker, I move to suspend the rules and pass the Senate bill (S. 268) to authorize the collection of fees for expenses for triploid grass carp certification inspections, and for other purposes.

The Clerk read as follows:

S. 268

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. COLLECTION OF FEES FOR TRIPLOID GRASS CARP CERTIFICATION INSPECTIONS.

(a) IN GENERAL.—The Secretary of the Interior, acting through the Director of the Fish and Wildlife Service (referred to in this section as the ''Director''), may charge reasonable fees for expenses to the Federal Government for triploid grass carp certification inspections requested by a person who owns or operates an aquaculture facility.

(b) AVAILABILITY.—All fees collected under subsection (a) shall be available to the Director until expended, without further appropriations.

(c) USE.—The Director shall use all fees collected under subsection (a) to carry out the activities referred to in subsection (a).

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey [Mr. SAXTON] will be recognized for 20 minutes, and the gentleman from California [Mr. MILLER] will be recognized for 20 minutes.

The Chair recognizes the gentleman from New Jersey [Mr. SAXTON].

Mr. SAXTON. Mr. Speaker, I rise in support of S. 268. This legislation establishes a fee-for-service system whereby the Secretary of the Interior may collect fees from private fish producers for the cost of grass carp certification inspections. It also allows the U.S. Fish and Wildlife Service to retain those funds for that program.

This legislation is important because many States require that grass carp, which are imported by these States to eat aquatic vegetation, must be certified as sterile or triploid. This is to ensure that these carp do not reproduce and have an adverse effect on the environment.

The Fish and Wildlife Service has been certifying the sterility of grass carp since 1979. In fiscal year 1994, over $70,000 was spent by the Service on this program. Due to budget constraints, however, the Fish and Wildlife Service has announced that it is no longer able to bear the cost of this program. Private producers have notified the Service that they are willing to pay certification costs. This legislation will allow the fee-for-service to be established so the Service can continue the program at no cost to the Federal Government.

This legislation was the subject of a hearing in my subcommittee on June 8 and it was unanimously approved by the House Resources Committee.

It is an excellent example of how a user fee can be established that is both beneficial to those who receive the inspection services and to our taxpayers.

I want to compliment our distinguished colleague from Arkansas, BLANCHE LAMBERT LINCOLN, for her leadership on this legislation.

I urge an ''Aye'' vote on S. 268.

Mr. Speaker, I reserve the balance of my time.

Mr. MILLER of California. Mr. Speaker, I yield myself such time as I may consume.

(Mr. MILLER of California asked and was given permission to revise and extend his remarks.)

Mr. MILLER of California. Mr. Speaker, I strongly support this legislation, which is a very good example of a private-public partnership that benefits the taxpayers, private industry, and the environment.

Mr. Speaker, I yield such time as she may consume to the gentlewoman from Arkansas [Mrs. LINCOLN].

(Mrs. LINCOLN asked and was given permission to revise and extend her remarks.)

Mrs. LINCOLN. Mr. Speaker, I would like to thank the gentleman from California, Mrs. MILLER, as well as the gentleman from New Jersey, Chairman SAXTON, for their assistance in this matter.

Mr. Speaker, I rise to urge adoption of this legislation before the House today that epitomizes the type of relationship that should exist between private industry and the Federal Government.

For the past several years the Fish and Wildlife Service has conducted a certification program for the triploid grass carp. This beneficial fish is utilized by 29 States to help control aquatic vegetation in lakes ponds, and streams. The triploid grass carp provides an effective, economical method of caring for these environments without the use of chemical agents.

As the use of the fish has increased over the years, a number of States have adopted regulations which require the grass carp to be certified as sterile. If a reproducing carp were introduced into these environments it could cause serious damage to the existing fish species. The certification process has assured States that the fish were sterile, thereby allowing their shipment by private aquaculturists.

In the past year the Fish and Wildlife Service conducted 550 triploid grass carp inspections at no charge to the producer. The cost of the program was $70,000. However, this year because of the dire fiscal situation that faces many agencies, the Fish and Wildlife Service has indicated that it cannot afford to operate the program.

The producers who have utilized this program have agreed to pay a fee that would cover the entire cost of the program with the understanding that the funds would be utilized for this purpose only. The Fish and Wildlife Service supports this arrangement but lacks the authority to implement it without congressional authorization.

This bill is identical to one that I introduced earlier this year and I appreciate the support of Chairman SAXTON, Chairman YOUNG, and Congressmen STUDDS in bringing this measure to the floor today. I urge my colleagues to support this legislation.

Mr. MILLER of California. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I want to commend the gentlewoman from Arkansas [Mrs. LINCOLN] for her work on this legislation. She has garnered partisan support for this legislation. We urge support of the bill.

Mr. Speaker, I yield back the balance of my time.

Mr. SAXTON. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would just like to build on the comments of the gentleman from California, Mr. MILLER. The gentlewoman from Arkansas, Mrs. LINCOLN, has in fact done a yeoman's job on this bill in an atmosphere where partisan politics seems to play an overly aggressive role around here, both on the committee level and here on the House floor.

She has been able to, No. 1, fashion a bill that makes sense and, No. 2, to get support, I believe almost unanimous support, on the committee in a very, very businesslike and professional way. We appreciate that approach and are glad to have been able to work with the gentlewoman on this.

Mr. YOUNG of Alaska. Mr. Speaker, I strongly support S. 268 and feel it is appropriate to allow private fish producers to fully reimburse the U.S. Fish and Wildlife Service for the costs of their certification to triploid grass carp.

The U.S. Fish and Wildlife Service began its involvement in the DNA certification of triploid grass carp nearly two decades ago. Since that time, the program has grown to more than 550 inspections per year for private producers whose fish are shipped to some 30 States. In fiscal year 1994, over $70,000 was spent by the Service on this program.

This certification process is necessary to ensure that only sterile grass carp are released in public and private waters to control aquatic vegetation.

Earlier this year, the Fish and Wildlife Service announced its intention to terminate this certification program. Since States will not allow the release of grass carp without the Service's stamp of approval, this legislation has become necessary.

S. 268 will establish a fee-for-service system and it will allow the Fish and Wildlife Service to retain those collected funds to cover the expenses of the triploid grass carp certification inspections.

I urge an ''aye'' vote on this measure and compliment our colleague, BLANCHE LAMBERT LINCOLN, for her leadership in bringing this matter to our attention.

Mr. SAXTON. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. RIGGS). The question is on the motion offered by the gentleman from New Jersey [Mr. SAXTON] that the House suspend the rules and pass the Senate bill, S. 268.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the Senate bill was passed.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. SAXTON. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on S. 268, the bill just passed.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

EXTENDING CERTAIN VETERANS' AFFAIRS HEALTH AND MEDICAL CARE EXPIRING AUTHORITIES

Mr. STUMP. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2353) to amend title 38, United States Code, to extend certain expiring authorities of the Department of Veterans' Affairs relating to delivery of health and medical care, and for other purposes, as amended.

The Clerk read as follows:

H.R. 2353

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. EXTENSION OF EXPIRING AUTHORITIES OF DEPARTMENT OF VETERANS AFFAIRS.

(a) HOSPITAL CARE AND MEDICAL SERVICES FOR PERSIAN GULF VETERANS EXPOSED TO TOXIC SUBSTANCES.—(1) Section 1710(e)(3) of title 38, United States Code, is amended by striking out ''December 31, 1995'' and inserting in lieu thereof ''December 31, 1998''.

(2) Section 1712(a)(1)(D) of such title is amended by striking out ''December 31, 1995'' and inserting in lieu thereof ''December 31, 1998''.

(b) CONTRACT AUTHORITY FOR ALCOHOL AND DRUG ABUSE CARE.—Subsection (e) of section 1720A of such title is amended by striking out ''December 31, 1995'' and inserting in lieu thereof ''December 31, 1997''.

(c) NURSING HOME CARE ALTERNATIVES.—(1) Section 1720C(a) of such title is amended by striking out ''September 30, 1995'' and inserting in lieu thereof ''December 31, 1997''.

(2) The Secretary of Veterans Affairs shall submit to Congress, not later than March 31, 1997, a report on the medical efficacy and cost effectiveness, and disadvantages and advantages, associated with the use by the Secretary of noninstitutional alternatives to nursing home care.

(d) HEALTH SCHOLARSHIPS PROGRAM.—(1) Section 7618 of such title is amended by striking out ''December 31, 1995'' and inserting in lieu thereof ''December 31, 1997''.

(2)(A) The Secretary of Veterans Affairs shall submit to Congress, not later than March 31, 1997, a report setting forth the results of a study evaluating the operation of the health professional scholarship program under subchapter II of chapter 76 of title 38, United States Code. The study shall evaluate the efficacy of the program with respect to recruitment and retention of health care personnel for the Department of Veterans Affairs and shall compare the costs and benefits of the program with the costs and benefits of alternative methods of ensuring adequate recruitment and retention of such personnel.

(B) The Secretary shall carry out the study under this paragraph through a private contractor. The report under subparagraph (A) shall include the report of the contractor and the comments, if any, of the Secretary on that report.

(e) ENHANCED-USE LEASES OF REAL PROPERTY.—(1) Section 8169 of such title is amended by striking out ''December 31, 1995'' and inserting in lieu thereof ''December 31, 1997''.

(2) The Secretary of Veterans Affairs shall submit to Congress, not later than March 31, 1997, a report evaluating the operation of the program under subchapter V of chapter 81 of title 38, United States Code.

(f) COMMUNITY-BASED RESIDENTIAL CARE FOR HOMELESS CHRONICALLY MENTALLY ILL VETERANS.—Section 115(d) of the Veterans' Benefits and Services Act of 1988 (Public Law 100–322; 38 U.S.C. 1712 note) is amended by striking out ''September 30, 1995'' and inserting in lieu thereof ''December 31, 1997''.

(g) DEMONSTRATION PROGRAM OF COMPENSATED WORK THERAPY AND THERAPEUTIC TRANSITIONAL HOUSING.—Section 7 of Public Law 102–54 (38 U.S.C. 1718 note) is amended—

(1) in subsection (a), by striking out ''During fiscal years 1991 through 1995, the Secretary'' and inserting in lieu thereof ''The Secretary''; and

(2) by adding at the end the following:

''(m) SUNSET.—The authority for the demonstration program under this section expires on December 31, 1997.''.

(h) HOMELESS VETERANS PILOT PROGRAM.—The Homeless Veterans Comprehensive Service Programs Act of 1992 (Public Law 102–590) is amended as follows:

(1) Section 2(a) (38 U.S.C. 7721 note) is amended by striking out ''September 30, 1995'' and inserting in lieu thereof ''December 31, 1998''.

(2) Section 3(a) (38 U.S.C. 7721 note) is amended by striking out '', during fiscal years 1993, 1994, and 1995,''.

(3) Section 12 (38 U.S.C. 7721 note) is amended by striking out ''each of the fiscal years 1993, 1994, and 1995'' and inserting in lieu thereof ''each fiscal year through 1998''.

SEC. 2. REPORTS.

(a) REPORT ON CONSOLIDATION OF CERTAIN PROGRAMS.—The Secretary of Veterans Affairs shall submit to Congress, not later than March 1, 1997, a report on the advantages and disadvantages of consolidating into one program the following three programs:

(1) The alcohol and drug abuse contract care program under section 1720A of title 38, United States Code.

(2) The program to provide community-based residential care to homeless chronically mentally ill veterans under section 115 of the Veterans' Benefits and Services Act of 1988 (38 U.S.C. 1712 note).

(3) The demonstration program under section 7 of Public Law 102–54 (38 U.S.C. 1718 note).

(b) REPORT ON SCIENTIFIC EVIDENCE CONCERNING HEALTH CONSEQUENCES OF MILITARY SERVICE IN PERSIAN GULF WAR.—(1) The Secretary of Veterans Affairs shall, in consultation with the National Academy of Sciences and with officials of other appropriate Federal departments and agencies, review the scientific evidence, and assess the strength of such evidence, concerning association between military service in the Southwest Asia theater of operations during the Persian Gulf War and any disease that may be associated with such service.

(2) The Secretary shall, not later than March 1, 1998, submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the findings of the review and assessment under paragraph (1).

SEC. 3. REPEAL OF AUTHORITY TO MAKE GRANTS TO VETERANS MEMORIAL MEDICAL CENTER IN THE PHILIPPINES.

(a) REPEAL.—Section 1732 of title 38, United States Code, is amended—

(1) by striking out subsection (b);

(2) by redesignating subsection (c) as subsection (b) and striking out ''or grant'' both places it appears in that subsection; and

(3) by redesignating subsection (d) as subsection (c) and striking out ''and to make grants'' in that subsection.

(b) CLERICAL AMENDMENTS.—(1) The heading of such section is amended by striking out ''**and grants**''.

(2) The item relating to such section in the table of sections at the beginning of chapter 17 of such title is amended by striking out ''and grants''.

SEC. 4. DISPLAY OF POW/MIA FLAG AT DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTERS.

(a) DAILY DISPLAY OF FLAG.—Subsection (a) of section 1084 of the National Defense Authorization Act for Fiscal Years 1992 and 1993 (Public Law 102–190; 36 U.S.C. 189 note) is amended—

(1) by striking out ''and'' at the end of paragraph (1);

(2) by striking out the period at the end of paragraph (2) and inserting in lieu thereof ''; and''; and

(3) by adding at the end the following:

''(3) on, or on the grounds of, each Department of Veterans Affairs medical center (except as provided in subsection (e)), on every day on which the flag of the United States is displayed.''.

(b) EXCEPTION FOR CERTAIN DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTERS.—Such section is further amended—

(1) by redesignating subsection (e) as subsection (f); and

(2) by inserting after subsection (d) the following new subsection (e):

''(e) SPECIAL RULE FOR DISPLAY AT DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTERS.—(1) Upon a determination by the director of a Department of Veterans Affairs medical center that the daily display of the POW/MIA flag at that medical center may be detrimental to the treatment of patients at that center, the provisions of subsection (a)(3) shall be inapplicable with respect to that medical center.

''(2) Whenever the director of a Department of Veterans Affairs medical center makes a determination described in paragraph (1), that officer shall submit a report on such determination, including the basis for the determination, to the Under Secretary for Health of the Department of Veterans Affairs.''.

(c) PROCUREMENT AND DISTRIBUTION OF FLAGS.—(1) Subsection (c) of such section is amended by striking out ''Within 30 days after the date of the enactment of this Act, the Administrator'' and inserting in lieu thereof ''The Administrator''.

(2) The Administrator of General Services shall carry out subsection (c) of section 1084 of the National Defense Authorization Act for Fiscal Years 1992 and 1993 (Public Law 102–190; 36 U.S.C. 189 note) with respect to the procurement and distribution of POW/MIA flags for the purposes of paragraph (3) of subsection (a) of such section (as added by subsection (a) of this section) within 30 days after the date of the enactment of this Act.

SEC. 5. CONTRACTS FOR UTILITIES, AUDIE L. MURPHY MEMORIAL HOSPITAL.

(a) AUTHORITY TO CONTRACT.—Subject to subsection (b), the Secretary of Veterans Affairs may enter into contracts for the provision of utilities (including steam and chilled water) to the Audie L. Murphy Memorial Hospital in San Antonio, Texas. Each such contract may—

(1) be for a period not to exceed 35 years;

(2) provide for the construction and operation of a production facility on or near property under the jurisdiction of the Secretary;

(3) require capital contributions by the parties involved for the construction of such a facility, such contribution to be in the form of cash, equipment, or other in-kind contribution; and

(4) provide for a predetermined formula to compute the cost of providing such utilities to the parties for the duration of the contract.

(b) FUNDS.—A contract may be entered into under subsection (a) only to the extent as provided for in advance in appropriations Acts.

(c) ADDITIONAL TERMS.—The Secretary may include in a contract under subsection (a) such additional provisions as the Secretary considers necessary to secure the provision of utilities and to protect the interests of the United States.

SEC. 6. NAME OF DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER, WALLA WALLA, WASHINGTON.

The Department of Veterans Affairs Medical Center located at 77 Wainwright Drive, Walla Walla, Washington, shall after the date of the enactment of this Act be known and designated as the ''Jonathan M. Wainwright Department of Veterans Affairs Medical Center''. Any reference to that medical center in any law, regulation, map, document, paper, or other record of the United States shall be considered to be a reference to the Jonathan M. Wainwright Department of Veterans Affairs Medical Center.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Arizona [Mr. STUMP] will be recognized for 20 minutes, and the gentleman from Mississippi [Mr. MONTGOMERY] will be recognized for 20 minutes.

The Chair recognizes the gentleman from Arizona [Mr. STUMP].

GENERAL LEAVE

Mr. STUMP. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 2353.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Arizona?

There was no objection.

Mr. STUMP. Mr. Speaker, I yield myself such time as I may consume.

(Mr. STUMP asked and was given permission to revise and extend his remarks.)

Mr. STUMP. Mr. Speaker, H.R. 2353 would extend various authorities of the Department of Veterans Affairs relating to delivery of health care for eligible veterans.

These include: Hospital care and medical services for Persian Gulf veterans; use of nursing home care alternatives; care for homeless veterans; and extension of the VA Health Scholarship program.

H.R. 2353 would also: Provide for the daily display of the POW/MIA flag at VA medical centers; authorize VA to contract for utilities at the Audie Murphy Memorial Veterans Hospital in San Antonio, TX; and, change the name of the Walla Walla, Washington VA Medical Center to the Jonathan M. Wainwright VA Medical Center.

As with all VA medical care authorizations, these provisions would be subject to annual appropriation levels.

The Congressional Budget Office has stated this bill would not affect direct spending or receipts; thus it would have no pay-as-you-go implications under budget rules.

As always, I want to thank the VA Committee's ranking member, my distinguished colleague SONNY MONTGOMERY for his cooperation and assistance on this bill.

I also want to thank CHRIS SMITH, vice-chairman of the VA Committee, the chairman of the Hospital and Health Care Subcommittee, TIM HUTCHINSON, and the subcommittee's ranking member, CHET EDWARDS, for their bipartisan work on this measure.

They worked in a very constructive fashion with other members of the committee to resolve differences of opinion and accommodate Members desires in regard to this legislation.

Mr. FOX, a member of the Hospitals and Health Care Subcommittee should be acknowledged for his instruction of the provision regarding flying the POW/MIA flag at VA medical centers.

Additionally, I would like to acknowledge the contribution of Mr. NETHERCUTT of Washington, for his leadership in renaming the VA medical center in Walla Walla, in honor of Gen. Jonathan M. Wainwright.

General Wainwright was an extremely distinguished military and civic leader, so it is very fitting that we take this action in his memory.

Mr. Speaker, I yield such time as he may consume to the gentleman from New Jersey [Mr. SMITH], the vice chairman of the committee, for an explanation of the bill.

Mr. SMITH of New Jersey. Mr. Speaker, I strongly support H.R. 2353, legislation to extend eight needed expiring authorities for the Department of Veterans Affairs, including other important provisions. Before I summarize the bill I would like to express my sincere appreciation for the bipartisan effort and the outstanding work by those who brokered the compromises reflected in the bill. Through the efforts of Chairman HUTCHINSON and Chairman STUMP, along with full committee ranking member MONTGOMERY, and CHET EDWARDS, the ranking member of the subcommittee, we were able to reach a compromise that reflects not only the specific concerns of each of the members but also the needs of our veteran constituents. We were also, in the spirit of compromise, able to address the concerns of Mr. NETHERCUTT and the entire Washington State delegation to rename the Walla Walla VA Medical Center for a Great Washingtonian, Gen. Jonathan M. Wainwright.

Under this bill, hospital and medical care services for Persian Gulf veterans will be extended for 3 years, until December 31, 1998.

This bill also extends the following seven authorities: Contract authority for alcohol and drug abuse care through December 31, 1997; the nursing home care alternatives program through December 31, 1997 with an evaluation due to Congress March 31, 1997; The Health Scholarships program to December 31, 1997, with a report by a private contractor due to Congress March 31, 1997; enhanced-use lease of real property authority to December 31, 1997 with a report due to Congress March 31, 1997; the community-based residential care for homeless chronically mentally ill veterans to December 31, 1997; the demonstration program of compensated work therapy and therapeutic transitional housing to December 31, 1997; and the homeless veterans pilot program to December 31, 1998.

Section 2 of the bill requires the VA to submit to Congress by March 1, 1997 a report on the advantages and disadvantages of consolidating the following programs: Alcohol and drug abuse contract care, community-based residential care to homeless chronically mentally ill veterans, and compensated work therapy and therapeutic transitional housing.

Section 2 also includes a compromise provision which authorizes a report on the scientific evidence concerning the health consequences of military service in the Persian Gulf war.

Section 3 of the bill repeals the authority of the VA to provide grants to the Veterans Memorial Medical Center in the Philippines.

Section 4 of the bill permits the daily display of the POW/MIA flag at Department of Veterans Affairs medical centers.

Section 5 authorizes contract authority for utilities at the Audie L. Murphy Memorial Medical Center, San Antonio, Texas.

Finally, Section 6 authorizes the name change of the Walla Walla VA Medical Center to the Jonathan M. Wainwright Department of Veterans Affairs Medical Center, a great American hero and son of the State of Washington.

Mr. Speaker, this legislation is strongly supported by the Department, professional organizations representing the affected groups, and the Committee on Veterans' Affairs. Both the Subcommittee on Hospitals and Health Care and the full committee unanimously reported this measure. I strongly support passage of this legislation.

Mr. MONTGOMERY. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I want to start by thanking the gentleman from Arizona [Mr. STUMP], the chairman of the committee, for bringing this bill to the

floor. I also want to commend the gentleman from Arkansas [Mr. HUTCHINSON], and also the gentleman from New Jersey, [Mr. CHRIS SMITH], who handled the bill today. The gentleman from Arkansas [Mr. HUTCHINSON] is the chairman of the Subcommittee on Hospitals and Health Care, and also, the gentleman from Texas [Mr. CHET EDWARDS], the ranking member on this side, for their work in moving this measure to the House today.

As the gentleman from Texas [Mr. EDWARDS] said last week, along with the gentleman from Arizona [Mr. STUMP], we like to do things that affect veterans in a nonpartisan fashion, and this bill demonstrates our commitment to that principle.

Mr. Speaker, I would like to take a minute or two to talk about two important areas of this legislation. The first is the authority to provide health care on a priority basis to Persian Gulf veterans. Although the vast majority of these veterans do not have health concerns, there has been a great deal of attention paid to those with undiagnosed illnesses.

I would like to point out, Mr. Speaker, that in fact we passed historic legislation last year that if there is an undiagnosed illness of a veteran who was in the Persian Gulf, who served over in that faraway land, that that veteran can draw disability either for his or her family on a temporary basis until the research gets forward and helps us decide what the cause of that illness is. Both the Congress and the President are determined to get answers for those undiagnosed illnesses.

Mr. Speaker, I want to assure those veterans that if they need health care, I would hope they would go to the veterans hospital where they are, and they can try and we will try to search out the answers to some of these cases that have not been solved on the illness.

The second topic that I would like to briefly touch upon is the extension of the authorization for programs addressing the problems of veterans with mental illnesses. This bill authorizes the VA to continue to help veterans who are homeless or who have been recently discharged from the hospital.

The VA has a number of different programs to provide medical care, transitional housing and work therapy for these veterans. These are very important programs because they provide hope and dignity to veterans who have served their country and who are now suffering from the most invisible pain of mental illness. These veterans are very dependent on the Government for basic human needs and we have a special duty to continue to care for them.

Mr. Speaker, I urge my colleagues to support this bill.

Mr. Speaker, I yield such time as she may consume to the gentlewoman from Florida [Mrs. THURMAN].

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Mrs. THURMAN. Mr. Speaker, I thank the gentleman from Mississippi [Mr. MONTGOMERY] for yielding me this time, and I stand here ready to support H.R. 2353 and commend the work that has been done on this by the gentleman from Arizona [Mr. STUMP], the chairman of the committee. However, Members will hear me more than once on this issue for the next, at least for the 104th Congress, because I think there is something that needs to continue to be pointed out about veterans health care.

Mr. Speaker, in the U.S. Senate there was a Member that actually brought this up as well. I think the gentleman from Arizona [Mr. STUMP] might be well aware because he and I actually share some similar problems with Arizona and Florida.

As most of you know, Florida is a very popular veteran's destination. Between 1980 and 1990, the veterans population within my district increased immensely. For example, in Pasco County the number of veterans increased 56 percent; for Gilchrist County, it increased 63 percent; and in Marion County, the number of veterans increased 76 percent.

In the past, the VA has attempted to better allocate limited resources through the resource planning and management system [RPM]. Unfortunately, the Department of Veterans Affairs is reluctant to implement the proposals and findings of the RPM and rellocate resources to meet this shifting demand. According to a July 19, 1995, GAO report, the Department has failed to fully implement the new budgeting method known as the resource planning and management system.

The GAO stated:

> Because VHA lacked resources to fund all facilities' expected needs, it chose to limit the resources given to facilities with growing workloads. . . . For facilities with decreasing workloads, VHA chose not to reduce their funding in proportion to the expected decreases in workload. These decisions led only to small adjustments in the funding for the projected cost of increased workload, while facilities with decreasing workloads received more resources than they were projected to need.

In other words, those that were decreasing in workload actually were getting almost the same amount, while we that were increasing were getting less, or at least not meeting our needs.

Throughout the country, as well as in my home State of Florida, inequities exist in veterans health funding which need to be addressed. For example, the national average cost per veteran for medical services and administration as contained in the Department of Veterans Affairs Summary of Expenditures by State for fiscal year 1993 was $574. Florida, however, was allocating $405 per veteran for a veteran population of 1,719,022, the second largest veteran population in the Nation. Earlier in the summer, I pointed out that the total VA health care expenditures in Florida for fiscal year 1994 were the same as total expenditure levels in Illinois and Pennsylvania, even though Florida's veteran population is 620,000 greater than Illinois and 330,000 greater than Pennsylvania's. In short, I would just like the chairman and the ranking member to know, I really believe we need to push for the Department of Veterans Affairs to allocate funding to ensure that veterans have equal access to quality health care regardless of what region they live in or which facility provides them services.

I think that is something all of us in this Congress believe we need to do to make sure that those men and women who fought for this country, some which have lost their lives, but those that returned, are given the same opportunities no matter where they live.

Again, Mr. Speaker, I thank the gentleman from Mississippi [Mr. MONTGOMERY] very much for his giving me the opportunity to bring this to the Congress' attention.

Mr. MONTGOMERY. Mr. Speaker, I would like to thank the gentlewoman for her comments. It is a problem we certainly will take a look at, and I think the gentleman from Arizona [Mr. STUMP] has about the same problem as she does as far as veterans moving into your area.

Mr. Speaker, I yield such time as he may consume to the gentleman from Texas [Mr. EDWARDS], the ranking member on the Subcommittee on Hospitals and Health Care. The gentleman from Texas has done a splendid job on that subcommittee and as a committee member of the Committee on Veterans' Affairs.

Mr. EDWARDS. Mr. Speaker, I thank the gentleman from Mississippi [Mr. MONTGOMERY] and I rise in support of H.R. 2353, as amended.

This bill, H.R. 2353, as amended, would extend VA's authority to provide needed services to veterans. Of particular importance, the bill would extend the period during which VA may furnish priority care to Persian Gulf veterans, without regard to whether health problems from which they suffer have been adjudicated as service incurred.

The bill would also permit VA to continue several high-visibility programs which help in rehabilitating homeless and chronically mentally ill veterans. These and other extensions in the bill are needed because in each instance the underlying legal authority to furnish care will expire on or before January 1, 1996.

H.R. 2353, as amended, would also underscore our commitment to achieving a full accounting of the status of American prisoners of war and missing in action by providing for display of the POW/MIA flag at VA medical centers.

Mr. Speaker, I especially want to pay tribute to the gentleman from Pennsylvania [Mr. FOX] for his leadership effort and fighting so that all Americans can be reminded of the fact that we do still have American MIA's and that we should never forget either our MIA's or our American POW's who have served this country. Had it not been for that gentleman's particular

leadership on this effort, I do not think this provision would be in the bill and he deserves our credit and our support for that leadership.

This bill also provides a framework for VA to achieve cost savings at the Audie Murphy VA Medical Center in San Antonio, TX, through contracts with a non-Federal institution for construction and shared use of an energy production facility.

I would like to commend my friend and colleague, the gentleman from Texas [Mr. TEJEDA], for his hard work on this provision. While Mr. TEJEDA is not here on the floor today because of a recent operation, our debt of thanks goes out to him. And if he happens to be watching this today, I know I speak on behalf of all of my colleagues in this House in saying we wish him well and appreciate his leadership and input on this bill.

Mr. Speaker, once again, it must be either a Monday or a Tuesday and it must once again be veterans legislation, because the chairman of the committee, the gentleman from Arizona [Mr. STUMP], and the ranking member, the gentleman from Mississippi [Mr. MONTGOMERY], have done their business one more time. They have crafted, with the help of the gentleman from Arkansas [Mr. HUTCHINSON], a bipartisan piece of legislation that is important to our Nation's veterans and they have brought it to the floor without discord, without fighting.

Mr. Speaker, there will not be anyone in the press gallery reporting on this, but, hopefully, once again, as happened last week and so many times before, the cooperative efforts of Mr. STUMP and Mr. MONTGOMERY have resulted in positive, good, constructive legislation coming through this House that will benefit millions of our Nation's veterans who have served our country.

Mr. MONTGOMERY. Mr. Speaker, will the gentleman, yield?

Mr. EDWARDS. I yield to the gentleman from Mississippi.

Mr. MONTGOMERY. Mr. Speaker, I appreciate the gentleman's mentioning the gentleman from Texas [Mr. TEJEDA], who is a member of the committee, and we are certainly pulling for him.

One thing I talked to the gentleman from Arizona [Mr. STUMP] about is, usually veterans bills are always up first in number. This time we are at the bottom, but I am sure that correction will be looked into, and I appreciate the gentleman's yielding.

Mr. EDWARDS. Mr. Speaker, I thank the gentleman. I am sure they just saved the best for last.

Mr. Speaker, I also want to congratulate the gentleman from Mississippi, [Mr. MONTGOMERY] and the gentleman from Arizona, [Mr. STUMP] and I urge support of this bill.

Mr. STUMP. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would like to acknowledge the very diligent work of the gentleman from Texas [Mr. EDWARDS]. He is always there, always willing to compromise, and stays right there. I thank both he and the gentleman from Pennsylvania [Mr. FOX] for resolving the issues of the POW–MIT problem of flying the flag at the VA centers and in working out their differences, and I commend both of them.

Mr. Speaker, I yield such time as he may consume to the gentleman from Pennsylvania [Mr. FOX].

Mr. FOX of Pennsylvania. Mr. Speaker, I too want to thank very much the gentleman from Arizona [Mr. STUMP], the chairman of the committee, and the ranking member, the gentleman from Mississippi [Mr. MONTGOMERY], and, of course, my colleague who has worked with me on this bill, the gentleman from Texas [Mr. EDWARDS], for his help in making this day possible, and also to the gentleman from Arkansas [Mr. HUTCHINSON], the chairman of the subcommittee, and to my good friend, the gentleman from New Jersey [Mr. SMITH], for his efforts in moving ahead this important veterans legislation.

In addition to extending expiring health care authorities, we act today to honor our commitment to the 2,202 brave American soldiers who are still missing or unaccounted for, and to their families.

It is our duty to remember these proud warriors and their families and to do everything within our power to obtain a full accounting. Particularly in light of the President's recent normalization of relations with Vietnam, we must ensure that we remain vigilant, Mr. Speaker, in our duty to American POW and MIA's. Today I am proud to join my colleagues on the Veterans' Affairs Committee in offering H.R. 2353, which includes a provision to have the POW/MIA flag flown daily at each Department of Veterans Affairs Medical Center until the President determines that the fullest possible accounting has been made.

As you know, Mr. Speaker, the National League of Families POW/MIA flag has been recognized by law as the Symbol of the Nation's concern and commitment to resolving as fully as possible the data on Americans still prisoner, missing, and unaccounted for. It is appropriate that this flag be flown at the institutions which we have established to care for those who have served our great country.

The POW/MIA flag is already flown daily at the Coatesville VA Medical Center in Coatesville, PA. Veterans there are grateful for this visible symbol of the concern and commitment of the U.S. Government to their missing brethren.

I would like to thank again Chairman STUMP, ranking member MONTGOMERY, Chairman HUTCHINSON, ranking member EDWARDS, with whom I have worked with so long, the gentleman from New Jersey, Mr. SMITH, the American Legion, and the national POW/MIA legislative network for their support and I urge my colleagues to fully support H.R. 2353.

Mr. MONTGOMERY. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. STUMP. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. RIGGS). The question is on the motion offered by the gentleman from Arkansas [Mr. STUMP] that the House suspend the rules and pass the bill, H.R. 2353, as amended.

The question was taken.

Mr. SMITH of New Jersey. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 5 of rule I and the Chair's prior announcement, further proceedings on this motion will be postponed.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12 of rule I, the Chair declares the House in recess until 5 p.m.

Accordingly (at 4 o'clock and 28 minutes p.m.), the House stood in recess until 5 p.m.

□ 1700

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. RIGGS) at 5 p.m.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 5, rule I, the Chair will now put the question on each question on which further proceedings were postponed earlier today in the order in which that question was entertained.

Votes will be taken in the following order:

First, the approval of the Journal, followed by votes on H.R. 2070 de novo and H.R. 2353 by the yeas and nays.

The Chair will reduce to 5 minutes the time for any electronic vote after the first such vote in this series.

THE JOURNAL

The SPEAKER pro tempore. Pursuant to clause 5 of rule I, the pending business is the question of the Speaker's approval of the Journal of the last day's proceedings.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Ms. MOLINARI. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 344, nays 53, answered ''present'' 2, not voting 33, as follows:

[Roll No. 714]

YEAS—344

Andrews	Edwards	Laughlin
Archer	Ehlers	Lazio
Armey	Ehrlich	Leach
Bachus	Emerson	Levin
Baesler	Engel	Lewis (CA)
Baker (CA)	English	Lewis (KY)
Baker (LA)	Eshoo	Lightfoot
Baldacci	Ewing	Lincoln
Ballenger	Farr	Linder
Barr	Fattah	Livingston
Barrett (NE)	Fawell	LoBiondo
Barrett (WI)	Fields (TX)	Lofgren
Bartlett	Flake	Lucas
Barton	Flanagan	Luther
Bass	Foley	Maloney
Bateman	Forbes	Manton
Beilenson	Ford	Manzullo
Bentsen	Fowler	Markey
Bereuter	Fox	Martinez
Berman	Frank (MA)	Martini
Bevill	Franks (CT)	Mascara
Bilbray	Franks (NJ)	Matsui
Bilirakis	Frelinghuysen	McCarthy
Bishop	Frisa	McCollum
Bliley	Frost	McCrery
Blute	Funderburk	McDermott
Boehlert	Furse	McHale
Boehner	Gallegly	McHugh
Bonilla	Ganske	McIntosh
Bonior	Gejdenson	McKeon
Bono	Gekas	McKinney
Borski	Geren	Meek
Boucher	Gilchrest	Metcalf
Brewster	Gilman	Meyers
Browder	Gonzalez	Mica
Brownback	Goodlatte	Miller (FL)
Bryant (TN)	Goodling	Minge
Bryant (TX)	Goss	Molinari
Bunn	Graham	Mollohan
Bunning	Green	Montgomery
Burr	Greenwood	Moorhead
Burton	Gunderson	Moran
Buyer	Gutknecht	Morella
Callahan	Hall (OH)	Murtha
Calvert	Hall (TX)	Myers
Camp	Hamilton	Myrick
Canady	Hancock	Nadler
Cardin	Hansen	Nethercutt
Castle	Hastert	Neumann
Chabot	Hastings (WA)	Norwood
Chenoweth	Hayes	Nussle
Christensen	Hayworth	Oberstar
Chrysler	Hefner	Obey
Clayton	Heineman	Olver
Clement	Herger	Ortiz
Clinger	Hobson	Orton
Clyburn	Hoekstra	Owens
Coble	Hoke	Oxley
Coburn	Holden	Packard
Collins (GA)	Horn	Pallone
Collins (IL)	Hostettler	Parker
Collins (MI)	Houghton	Pastor
Combest	Hunter	Paxon
Condit	Hutchinson	Payne (VA)
Cooley	Hyde	Pelosi
Costello	Inglis	Peterson (FL)
Cox	Istook	Peterson (MN)
Coyne	Johnson (CT)	Petri
Cramer	Johnson (SD)	Pomeroy
Crapo	Johnson, Sam	Porter
Cremeans	Johnston	Portman
Cubin	Jones	Poshard
Cunningham	Kanjorski	Pryce
Danner	Kaptur	Quillen
de la Garza	Kasich	Quinn
Deal	Kelly	Radanovich
DeFazio	Kennedy (RI)	Rahall
DeLauro	Kennelly	Ramstad
DeLay	Kildee	Rangel
Dickey	Kim	Reed
Dingell	King	Regula
Dixon	Kingston	Richardson
Doggett	Kleczka	Riggs
Dooley	Klink	Rivers
Doolittle	Klug	Roemer
Dornan	Knollenberg	Rogers
Doyle	Kolbe	Rohrabacher
Dreier	LaHood	Ros-Lehtinen
Duncan	Lantos	Rose
Dunn	Largent	Roth
Durbin	LaTourette	Roukema
Royce	Smith (TX)	Vucanovich
Salmon	Smith (WA)	Walker
Sanders	Souder	Walsh
Sanford	Spence	Wamp
Sawyer	Spratt	Ward
Saxton	Stearns	Watts (OK)
Schaefer	Stenholm	Waxman
Schiff	Stokes	Weldon (FL)
Schumer	Studds	Weldon (PA)
Scott	Stupak	Weller
Seastrand	Talent	White
Sensenbrenner	Tanner	Whitfield
Serrano	Tate	Williams
Shadegg	Tauzin	Wilson
Shaw	Taylor (NC)	Wise
Shays	Thomas	Wolf
Shuster	Thornberry	Woolsey
Sisisky	Thornton	Wyden
Skaggs	Thurman	Wynn
Skeen	Tiahrt	Yates
Skelton	Torres	Young (AK)
Slaughter	Torricelli	Young (FL)
Smith (MI)	Traficant	Zeliff
Smith (NJ)	Upton	

NAYS—53

Allard	Gutierrez	Rush
Becerra	Hastings (FL)	Sabo
Brown (CA)	Hefley	Scarborough
Brown (FL)	Hilliard	Schroeder
Brown (OH)	Jacobs	Stark
Clay	Johnson, E. B.	Stockman
Coleman	LaFalce	Stump
Conyers	Lewis (GA)	Taylor (MS)
Crane	Longley	Thompson
Davis	McNulty	Torkildsen
Dicks	Mfume	Velazquez
Evans	Miller (CA)	Vento
Everett	Neal	Visclosky
Fazio	Ney	Waters
Filner	Pickett	Watt (NC)
Gephardt	Pombo	Wicker
Gibbons	Roberts	Zimmer
Gillmor	Roybal-Allard	

ANSWERED ''PRESENT''—2

Hoyer	Lipinski

NOT VOTING—33

Abercrombie	Gordon	Meehan
Ackerman	Harman	Menendez
Barcia	Hilleary	Mink
Chambliss	Hinchey	Moakley
Chapman	Jackson-Lee	Payne (NJ)
Dellums	Jefferson	Solomon
Deutsch	Kennedy (MA)	Tejeda
Diaz-Balart	Latham	Towns
Ensign	Lowey	Tucker
Fields (LA)	McDade	Volkmer
Foglietta	McInnis	Waldholtz

□ 1724

Mr. ALLARD changed his vote from ''yea'' to ''nay.''

Mr. HASTINGS of Washington changed his vote from ''nay'' to ''yea.''

Mr. JOHNSTON of Florida changed his vote from ''present'' to ''yea.''

So the Journal was approved.

The result of the vote was announced as above recorded.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. RIGGS). Pursuant to the provisions of clause 5 of rule I, the Chair announces that he will reduce to a minimum of 5 minutes the period of time within which the vote by electronic device may be taken on each motion to suspend the rules on which the Chair has postponed further proceedings.

PROVIDING FOR DISTRIBUTION OF USIA FILM ''FRAGILE RING OF LIFE''

The SPEAKER pro tempore. The pending business is the question de novo of suspending the rules and passing the bill, H.R. 2070.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey [Mr. SMITH] that the House suspend the rules and pass the bill, H.R. 2070.

The question was taken.

RECORDED VOTE

Mr. CAMP. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 403, noes 2, not voting 27, as follows:

[Roll No. 715]

AYES—403

Allard	Cox	Goss
Andrews	Coyne	Graham
Archer	Cramer	Green
Armey	Crane	Greenwood
Bachus	Crapo	Gunderson
Baesler	Cremeans	Gutierrez
Baker (CA)	Cubin	Gutknecht
Baker (LA)	Cunningham	Hall (OH)
Baldacci	Danner	Hall (TX)
Ballenger	Davis	Hamilton
Barr	de la Garza	Hancock
Barrett (NE)	Deal	Hansen
Barrett (WI)	DeFazio	Hastert
Bartlett	DeLauro	Hastings (FL)
Barton	DeLay	Hastings (WA)
Bass	Dellums	Hayes
Bateman	Diaz-Balart	Hayworth
Becerra	Dickey	Hefley
Beilenson	Dicks	Hefner
Bentsen	Dingell	Heineman
Bereuter	Dixon	Herger
Berman	Doggett	Hilliard
Bevill	Dooley	Hobson
Bilbray	Doolittle	Hoekstra
Bilirakis	Dornan	Hoke
Bishop	Doyle	Holden
Bliley	Dreier	Horn
Blute	Duncan	Hostettler
Boehlert	Dunn	Houghton
Boehner	Durbin	Hoyer
Bonilla	Edwards	Hunter
Bonior	Ehlers	Hutchinson
Bono	Ehrlich	Hyde
Borski	Emerson	Inglis
Boucher	Engel	Istook
Brewster	English	Jacobs
Browder	Eshoo	Johnson (CT)
Brown (CA)	Evans	Johnson (SD)
Brown (FL)	Everett	Johnson, E. B.
Brown (OH)	Ewing	Johnson, Sam
Brownback	Farr	Johnston
Bryant (TN)	Fattah	Jones
Bryant (TX)	Fawell	Kanjorski
Bunn	Fazio	Kaptur
Bunning	Fields (TX)	Kasich
Burr	Filner	Kelly
Burton	Flake	Kennedy (RI)
Buyer	Flanagan	Kennelly
Callahan	Foley	Kildee
Calvert	Forbes	Kim
Camp	Ford	King
Canady	Fowler	Kingston
Cardin	Fox	Kleczka
Castle	Frank (MA)	Klink
Chabot	Franks (CT)	Klug
Chenoweth	Franks (NJ)	Knollenberg
Christensen	Frelinghuysen	Kolbe
Chrysler	Frisa	LaFalce
Clay	Frost	LaHood
Clayton	Furse	Lantos
Clement	Gallegly	Largent
Clinger	Ganske	LaTourette
Clyburn	Gejdenson	Laughlin
Coble	Gekas	Lazio
Coburn	Gephardt	Leach
Coleman	Geren	Levin
Collins (GA)	Gibbons	Lewis (CA)
Collins (IL)	Gilchrest	Lewis (GA)
Collins (MI)	Gillmor	Lewis (KY)
Combest	Gilman	Lightfoot
Condit	Gonzalez	Lincoln
Conyers	Goodlatte	Linder
Costello	Goodling	Lipinski

Livingston
LoBiondo
Lofgren
Longley
Lucas
Luther
Maloney
Manton
Manzullo
Markey
Martinez
Martini
Mascara
Matsui
McCarthy
McCollum
McCrery
McDermott
McHale
McHugh
McIntosh
McKeon
McKinney
McNulty
Meek
Menendez
Metcalf
Meyers
Mfume
Mica
Miller (CA)
Miller (FL)
Minge
Mink
Moakley
Molinari
Mollohan
Montgomery
Moorhead
Moran
Morella
Murtha
Myers
Myrick
Nadler
Neal
Nethercutt
Neumann
Ney
Norwood
Nussle
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Oxley
Packard
Pallone
Parker
Pastor
Paxon
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pombo
Pomeroy
Porter
Portman
Poshard
Pryce
Quillen
Quinn
Radanovich
Rahall
Ramstad
Rangel
Reed
Regula
Richardson
Riggs
Rivers
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Rose
Roth
Roukema
Roybal-Allard
Royce
Rush
Sabo
Salmon
Sanders
Sanford
Sawyer
Saxton
Scarborough
Schaefer
Schiff
Schroeder
Schumer
Scott
Seastrand
Sensenbrenner
Serrano
Shadegg
Shaw
Shays
Shuster
Sisisky
Skaggs
Skeen
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Solomon
Souder
Spence
Spratt
Stark
Stearns
Stenholm
Stockman
Stokes
Studds
Stump
Stupak
Talent
Tanner
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Thomas
Thompson
Thornberry
Thornton
Thurman
Tiahrt
Torkildsen
Torres
Torricelli
Traficant
Upton
Velazquez
Vento
Visclosky
Vucanovich
Walker
Walsh
Wamp
Ward
Waters
Watt (NC)
Watts (OK)
Waxman
Weldon (FL)
Weldon (PA)
Weller
White
Whitfield
Wicker
Williams
Wilson
Wise
Wolf
Woolsey
Wyden
Wynn
Yates
Young (AK)
Young (FL)
Zeliff
Zimmer

NOES—2

Cooley
Funderburk

NOT VOTING—27

Abercrombie
Ackerman
Barcia
Chambliss
Chapman
Deutsch
Ensign
Fields (LA)
Foglietta
Gordon
Harman
Hilleary
Hinchey
Jackson-Lee
Jefferson
Kennedy (MA)
Latham
Lowey
McDade
McInnis
Meehan
Payne (NJ)
Tejeda
Towns
Tucker
Volkmer
Waldholtz

☐ 1734

So (two-thirds having voted in favor thereof), the rules were suspended and the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

EXTENDING CERTAIN VETERANS' AFFAIRS HEALTH AND MEDICAL CARE EXPIRING AUTHORITIES

The SPEAKER pro tempore (Mr. FOGLIETTA). The pending business is the question of suspending the rules and passing the bill, H.R. 2353, as amended.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Arizona [Mr. STUMP] that the House suspend the rules and pass the bill, H.R. 2353, as amended, on which the yeas and nays are ordered.

The vote was taken by electronic device, and there were—yeas 403, nays 0, not voting 29, as following:

[Roll No. 716]

YEAS—403

Allard
Andrews
Archer
Armey
Bachus
Baesler
Baker (CA)
Baker (LA)
Baldacci
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Becerra
Beilenson
Bentsen
Bereuter
Berman
Bevill
Bilbray
Bilirakis
Bishop
Bliley
Blute
Boehlert
Boehner
Bonilla
Bonior
Bono
Borski
Boucher
Brewster
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Brownback
Bryant (TN)
Bryant (TX)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Cardin
Castle
Chabot
Chenoweth
Christensen
Chrysler
Clay
Clayton
Clement
Clinger
Clyburn
Coble
Coburn
Coleman
Collins (GA)
Collins (IL)
Collins (MI)
Combest
Condit
Conyers
Cooley
Costello
Cox
Coyne
Cramer
Crane
Crapo
Cremeans
Cubin
Cunningham
Danner
Davis
de la Garza
Deal
DeFazio
DeLauro
DeLay
Dellums
Diaz-Balart
Dickey
Dicks
Dingell
Dixon
Doggett
Dooley
Doolittle
Dornan
Doyle
Dreier
Duncan
Dunn
Durbin
Edwards
Ehlers
Ehrlich
Emerson
Engel
English
Eshoo
Evans
Everett
Ewing
Farr
Fattah
Fawell
Fazio
Fields (TX)
Filner
Flake
Flanagan
Foley
Forbes
Ford
Fowler
Fox
Frank (MA)
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Frost
Funderburk
Furse
Gallegly
Ganske
Gejdenson
Gekas
Gephardt
Geren
Gibbons
Gilchrest
Gillmor
Gilman
Gonzalez
Goodlatte
Goodling
Goss
Graham
Green
Greenwood
Gunderson
Gutierrez
Gutknecht
Hall (OH)
Hall (TX)
Hamilton
Hancock
Hansen
Hastert
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hefner
Heineman
Herger
Hilliard
Hinchey
Hobson
Hoekstra
Hoke
Holden
Horn
Hostettler
Houghton
Hoyer
Hunter
Hutchinson
Hyde
Inglis
Istook
Jacobs
Johnson (CT)
Johnson (SD)
Johnson, E. B.
Johnson, Sam
Johnston
Jones
Kanjorski
Kaptur
Kasich
Kelly
Kennedy (RI)
Kennelly
Kildee
Kim
King
Kingston
Kleczka
Klink
Klug
Knollenberg
Kolbe
LaFalce
LaHood
Lantos
Largent
LaTourette
Laughlin
Lazio
Leach
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Lightfoot
Lincoln
Linder
Lipinski
Livingston
LoBiondo
Lofgren
Longley
Lucas
Luther
Maloney
Manton
Manzullo
Markey
Martinez
Martini
Mascara
Matsui
McCarthy
McCollum
McCrery
McDermott
McHale
McHugh
McIntosh
McKeon
McKinney
McNulty
Meek
Menendez
Metcalf
Meyers
Mfume
Mica
Miller (CA)
Miller (FL)
Minge
Mink
Moakley
Molinari
Mollohan
Montgomery
Moorhead
Moran
Morella
Murtha
Myers
Myrick
Nadler
Neal
Nethercutt
Neumann
Ney
Norwood
Nussle
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Oxley
Packard
Pallone
Parker
Pastor
Paxon
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pombo
Pomeroy
Porter
Portman
Poshard
Pryce
Quillen
Quinn
Radanovich
Rahall
Ramstad
Rangel
Reed
Regula
Richardson
Riggs
Rivers
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Rose
Roth
Roukema
Roybal-Allard
Royce
Rush
Sabo
Salmon
Sanders
Sanford
Sawyer
Saxton
Scarborough
Schaefer
Schiff
Schroeder
Schumer
Scott
Seastrand
Sensenbrenner
Serrano
Shadegg
Shaw
Shays
Shuster
Sisisky
Skaggs
Skeen
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Solomon
Souder
Spence
Spratt
Stark
Stearns
Stenholm
Stockman
Stokes
Stump
Stupak
Talent
Tanner
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Thomas
Thompson
Thornberry
Thornton
Thurman
Tiahrt
Torkildsen
Torricelli
Traficant
Upton
Velazquez
Vento
Visclosky
Vucanovich
Walker
Walsh
Wamp
Ward
Waters
Watt (NC)
Watts (OK)
Waxman
Weldon (FL)
Weldon (PA)
Weller
White
Whitfield
Wicker
Williams
Wilson
Wise
Wolf
Woolsey
Wyden
Wynn
Yates
Young (AK)
Young (FL)
Zeliff
Zimmer

NOT VOTING—29

Abercrombie
Ackerman
Barcia
Barrett (WI)
Chambliss
Chapman
Deutsch
Ensign
Fields (LA)
Foglietta
Gordon
Harman
Hilleary
Jackson-Lee
Jefferson
Kennedy (MA)
Latham
Lowey
McDade
McInnis
Meehan
Payne (NJ)
Studds
Tejeda
Torres
Towns
Tucker
Volkmer
Waldholtz

☐ 1743

So (two-thirds having voted in favor thereof), the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Mr. BARCIA. Mr. Speaker, due to difficulties with return air flights from Michigan today, I was unable to vote on rollcalls 714, 715, and 716.

Had I been present, I would have voted "yea" on rollcall 714, the motion to approve the Journal, "aye" on rollcall 715 providing for U.S. distribution of the "Fragile Ring of Life" film, and "yea" on rollcall 716, extending certain Veterans' Affairs Health and Medical Care Expiring Authorities.

PERMISSION FOR COMMITTEE ON THE BUDGET TO FILE REPORT ON THE BUDGET RECONCILIATION ACT

Mr. MILLER of Florida. Mr. Speaker, I ask unanimous consent that the Committee on the Budget may have until midnight tonight to file the report to accompany the Budget Reconciliation Act.

The SPEAKER pro tempore (Mr. FOGLIETTA). Is there objection to the request of the gentleman from Florida?

There was no objection.

□ 1745

SPECIAL ORDERS

The SPEAKER pro tempore (Mr. FOLEY). Under the Speaker's announced policy of May 12, 1995, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

INCREASE DEBT CEILING NOW

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Florida [Mr. GIBBONS] is recognized for 5 minutes.

Mr. GIBBONS. Mr. Speaker, I am talking to the regularly elected Speaker of the House of Representatives, who happens to be the head of the Republican Party here in this Congress.

Mr. Speaker, three times the Secretary of the Treasury has written you this year asking you to move on increasing the debt ceiling. Every Member of your party has already voted to increase the debt ceiling to $5.5 trillion.

Why the delay, Mr. Speaker? Are you attempting to cause a Government wreck? You know, Mr. Speaker, that the Government runs out of borrowing authority. In fact, it is already out of borrowing authority, but is can only be stretched until the end of this month.

This is a serious matter. It is already costing the Federal taxpayers money. It already is acting as a tax increase to the tune of about $15 billion over a 6-year period. And your refusal to allow the debt ceiling legislation to come to the floor so that it can be extended can only be classified, as far as I am concerned, as an attempt to perpetuate a government wreck upon the American people.

Today the Treasury had to suspend selling special obligations to States and local governments. This will prevent the States and local governments from refinancing the debt that they had planned to refinance to reduce interest payments of their own citizens on those local debts. Already a number of States, including my own State of Florida, have had to cancel their refinancing because the Treasury window is not open, because the Treasury can no longer issue these obligations. This is just the first of a series of cascading events that are already in process.

Mr. Speaker, you have done some remarkable things in your short career around here, but you are the first person, Mr. Speaker, to remove and put the Federal obligations in the role of having a risk factor added to them. In 200 years the U.S. Government has never defaulted on an obligation.

Mr. Speaker, you said the other day that you did not care whether we defaulted on an obligation or not, you would keep the window closed on increasing the debt for as much as 60 days. I do not know who you are trying to bluff, but you ought to know, Mr. Speaker, that this is already costing the American taxpayers money, just like a tax would cost them money, this increase in interest rates.

A 10-point increase in basis points will cost the American taxpayers $15 billion over a 6-year period. This increase in basis points will also reduce the value of American private pension funds. Let me repeat this: This 10-point basis-point increase in interest rates that has already occurred and is occurring at this very moment, and it can get worse, has already cost the private pension plans $8 billion in assets.

Mr. Speaker, your actions are reckless. You need to bring up the debt ceiling legislation as rapidly as possible. Your obstinacy in doing this will prove nothing. Every Member of your party in both the House and the Senate have already voted to direct an increase in the debt ceiling until 1997, and the amount of money increase in the debt ceiling has already been fixed in legislation they are voting on.

I cannot think of anything you are doing, Mr. Speaker, except trying to blackmail the Government into a government wreck. This is irresponsible action. You should back off of that course of action immediately, Mr. Speaker.

CONGRESS SHOULD KEEP IN TOUCH WITH THEIR CONSTITUENTS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Georgia [Mr. KINGSTON] is recognized for 5 minutes.

Mr. KINGSTON. Mr. Speaker, you know, there are a lot of great statesmen that have walked through the halls of Congress for many years from both parties, people who have done so much with the budget, people who have done a lot with the Judiciary, people who have done a lot with the House rules and appropriations process. Fair men and women on both sides of the aisle have added so much to the institution. Sometimes people ask me, well, what is your identity? What great issue have you done?

I guess after thinking about this, oh, for a long time, Mr. Speaker, I would say, maybe I could be best described as the Congressman in the carpool line. Not really glamorous, but you know, I do, every Monday, drive the carpool. Then often after driving the carpool, I go over to the Piggly Wiggly, buy a little milk or whatever we happen to run out of. Then if you see me on a Saturday, I am at the soccer field. Our daughter plays soccer.

Often I will go to other things. Last weekend, for example, I went to Midway, GA, for an opening of a school down there, actually not an opening, but a new building of a school in the community that was an African-American community in coastal Georgia over 100 years ago. We are trying to restore that area. There is a lot of good leadership on that.

After that meeting I went to the Farm Bureau meeting in Folkston, GA. Then the next day, Mr. Speaker, I went to Odom, GA, to the Odom homecoming. The population of Odom last year went from 692 to over 700 people this year.

During this period, all day long, whether I am in the carpool line or at the grocery store or at the Farm Bureau meeting or at the Odom homecoming, people are coming up to me and asking me about Medicare, asking me about the budget, asking me about the debt ceiling. They are giving me opinions on Bosnia, and all kinds of different things, the space station B–2. Sometimes the questions are from people that know more about the issue than I do. Other times they are general questions. Generally they just want me to listen to them. I try my best to do that, Mr. Speaker, as I know every other Member of Congress does.

I think we can be proud that so many of our Members are good listeners. They do return back home. They do listen. But now let us compare ourselves to the other body. In this House, in this great U.S. Capitol, we have two bodies. We have the lower House and then we have the other body, which decorum does not permit me using their name. When we refer to the folks on the other side of the Capitol as the other body, I did not know we were speaking of a corpse. But that is what we are. We are speaking of folks who are not coming home and are not listening and not going to the grocery store and are not going to the homecomings and listening to the man and woman on the street on their different views.

I think as a result of that, Mr. Speaker, our product of government is not as good as it should be, because I believe that one of the key things we have to do as representative government is always remember who sent us here, why they sent us here, and remember the promises and the representations that were made to these folks.

We are going into a very critical period, Mr. Speaker. We have passed 12 appropriations bills. They are now in that other body. Some of them have come back and we have had some conference committee meetings on them. But the bulk of our work is still yet to be done. The bulk of our work, including not just finalization of the appropriations process, but the reconciliation, where we amass all the bills, all the legislation into one monster bill that we have to pass on both sides.

Through this process, I believe House Members in both parties have paid close attention to the constituents back home. A lot of our constituents in Georgia, for example, are saying you all are not going far enough. You are backing off on your promises. You are not doing what you said you are going to do. Maybe in some areas you have gone too far too fast. But people want us to listen, and they want to be assured that what we are doing is in the interests of what is best for the Republican Party but for the American public.

I believe that that is the case, Mr. Speaker. But I must say I worry about our friends on the other side of the aisle, if they are listening to the degree that they need to be listened to. I would urge the folks back home, because of that, to continue writing Members of the House and the Senate and give opinions on how they feel, because I do not think the message in every case is getting through. As we go into the budget process, right now it is even more important than other times.

Mr. Speaker, I yield to the gentleman from California [Mr. DORNAN], if he would like some time.

Mr. DORNAN. Mr. Speaker, I just wanted to tell the gentleman, I want to associate myself with his remarks. I am going to ask for a 5-minute special order here myself to discuss the infamous O.J. Simpson trial. I wanted to let the Chair know that I was going to ask for that when the gentleman is through. I certainly appreciate the 5-minute special order.

Mr. KINGSTON. Mr. Speaker, the gentleman from California is never without an opinion and never without truth and righteousness. It was refreshing to see the gentleman the other night spouting some of his views.

THE PROBLEM OF MEDICARE FRAUD AND ABUSE

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Connecticut [Ms. DELAURO] is recognized for 5 minutes.

Ms. DELAURO. Mr. Speaker, I am proud to kick off a series of 5-minute special orders this evening to address the growing problem of Medicare fraud and abuse. It is shameful that Members of Congress have been virtually denied the opportunity to discuss the leadership's proposal to cut Medicare by $270 billion, and it is unprecedented its rollback of Medicare fraud law enforcement.

The Republican plan would devastate Medicare to pay for a tax giveaway for the wealthy, but it also misses a golden opportunity to fix a major problem with Medicare. In fact, it actually makes this serious problem worse. The GOP plan actually will make it easier for Medicare cheats to get away with their health care scams. This plan rips off American taxpayers and American seniors.

Many of us are genuinely concerned with strengthening the Medicare system, and we have urged a crackdown on Medicare fraud. I am happy that some of my colleagues have joined with me tonight to talk about this critical issue. I am proud to commend the gentleman from Michigan [Mr. LEVIN] for his commitment to combatting fraud and abuse in Medicare. The gentleman from Michigan plays a key role on the Committee on Ways and Means in the effort to toughen the punishments for fraud and strengthening our enforcement capabilities.

I would like to recognize the gentleman from Illinois [Mr. DURBIN], an original cosponsor of my legislation, the Health Care Prosecution Act, to combat fraud and abuse in our health care system. The gentleman has been a leader in the fight to defeat the GOP's Medicare cuts and to restore integrity to the Medicare program for our elderly.

□ 1800

I also would like to thank the gentleman from New Jersey, Mr. FRANK PALLONE, and the gentleman from Ohio, Mr. SHERROD BROWN, for joining us tonight. Their work on the Committee on Commerce to remedy fraud and abuse in the Medicare system has been invaluable.

We are here tonight, Mr. Speaker, to let the American people know that the Republican bill does not, let me repeat, it does not toughen enforcement measures. It does not even defend the status quo. Far worse, the Republicans turn back the clock on Medicare fraud enforcement.

Just today, Mr. Speaker, the Inspector General of Health and Human Services and the Justice Department that monitors, the policemen, if you will, the fraud that occurs in the health care system said that the Republican proposal would make it harder for the government to obtain convictions under an anti-kickback statute, and, in fact, would cripple the Justice Department's ability to crack down on health care fraud.

The Congressional Budget Office estimates that stopping the growing problem of fraud could save as much as $80 billion. And despite this evidence, the GOP plan does nothing to crack down on waste, fraud and abuse. That is because the plan has nothing to do with fixing Medicare, it has everything to do with providing the Republicans' rich political supporters with a fat tax giveaway.

Mr. Speaker, while I am sadly disappointed, I am not surprised, as the Washington Times, not exactly a liberal publication, reported last week Speaker Gingrich dismissed the necessity of cracking down on Medicare cheats by suggesting that we have insufficient jail space to lock up all the crooks in the system. The GOP shows no hesitation to crack down on the elderly, the sick, the disabled, the poor, and the young in their plan. But when it comes to targeting the real bad guys, the Republicans suddenly express concern about inadequate vacant correctional facility space.

The congressional leadership is not interested in correcting and punishing the criminal elements in the Medicare system. However, I have introduced legislation in this Congress, the Health Care Prosecution Act, to do just that. My bill stops health care cheats in their tracks. It retrieves the financial losses in restitution and fines and it puts the criminals behind bars so that they are unable to pull off more health care scams in the future.

Further, my legislation establishes a temporary health care fraud and abuse commission to study the nature and the extent of fraud in our system. This blue ribbon panel would make recommendations to Congress on innovative approaches to attack fraud.

Mr. Speaker, there are a lot of good ideas out there about how to attack Medicare fraud, waste and abuse. I am sorry that my Republican colleagues have chosen to pursue none of that.

Mr. Speaker, I am delighted to be joined by additional colleagues tonight who will also address this issue of Medicare fraud and abuse and the way that we might address it, and that it is not addressed in the Republican proposal.

REPUBLICANS WEAKEN FRAUD AND ABUSE PROVISIONS IN THEIR BILL

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Michigan [Mr. LEVIN] is recognized for 5 minutes.

Mr. LEVIN. Mr. Speaker, I congratulate the gentlewoman from Connecticut [Ms. DELAURO] for talking about this issue, and I would like to say a few words as a Member of the Committee on Ways and Means.

Mr. Speaker, we worked on this issue. I was deeply disappointed with the product that came out of the committee: $270 billion in Medicare cuts in order to pay for a tax break, mostly for wealthy families, is bad enough, doubling the monthly premium for seniors in part B, the physician and other provider part of Medicare, is bad enough, especially when we take into account, for example, looking at Michigan, that 85 percent of the seniors in Michigan have an income annually of less than $25,000 and $15,000 is the annual income of 70 percent of the seniors.

So doubling the premium is bad enough, Mr. Speaker, but the Republicans went further and they weakened the fraud and abuse provisions of Medicare. They weakened them.

Mr. Speaker, I want to refer to a few documents. There are two sets of penalties involved: one is criminal, where there is intentional serious fraudulent action; and the other is monetary civil penalties, where the offense is less serious. Both of them are weakened.

The criminal is weakened by adding a provision requiring that the significant

purpose of the effort must have been inducing essentially fraudulent or other similar activity.

On this, here is what the Justice Department says, Mr. Speaker. This is of the Republicans that is now in the bill that will be before us on Thursday. ''The proposed amendment will seriously undercut our anti-kickback enforcement efforts''. This is the Justice Department. The Republicans did not listen to them.

Here is what the Inspector General of the Health and Human Services department says. ''These proposals would cripple the efforts of law enforcement agencies to control health care fraud and abuse in the Medicare program and to bring wrongdoers to justice''.

Here is what the GAO says about the change in the Republican bill in the criminal statute. ''The effect could well be to make it easier to disguise the intent behind kickback arrangements or make disguises currently used more effective in evading prosecution''.

In a word, Mr. Speaker, when it comes to criminal sanctions against fraud and abuse, the bill that will be before us on Thursday would make it much more difficult and would weaken our efforts. And, look, the HHS IG points out that the GAO estimates loss to Medicare from fraud and abuse at 10 percent of total Medicare expenditures, or about $18 billion.

Why then, Mr. Speaker, are the Republicans weakening these provisions?

There is also a weakening of the monetary provisions, the civil provisions, and, here again, there is no reason to do it. Here is what the GAO says. ''We agree with the Inspector General of HHS that this new definition of 'should know', which essentially would require proof of reckless activity, would, as drafted, significantly curtail enforcement under the Medicare civil monetary penalty provisions''. Significantly curtail enforcement.

Now, why is this being done? The Washington Times, October 4, the headline is GOP's Medicare plan takes hit for weakness in stopping fraud. Why are the Republicans doing this? It is terribly misguided.

Searching for a reason, the Speaker, on October 12, said this. ''The speaker defended GOP moves to reduce penalties and enforcement efforts against Medicare fraud by saying it is more important to lock up murderers and rapists than dishonest doctors''.

I think the answer is, Mr. Speaker, we can do both. We should, obviously, lock up everybody, everybody who is convicted of murder and rape. However, that is not an excuse to let dishonest providers off the hook.

Mr. Speaker, I urge everybody to take a look at this. This Republican effort is terribly misguided.

REPUBLICANS MEDICARE BILL WORSENS PROBLEM OF FRAUD AND ABUSE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New Jersey [Mr. PALLONE] is recognized for 5 minutes.

Mr. PALLONE. Mr. Speaker, I also want to address the problem of waste, fraud, and abuse in Medicare and say that I am very pleased to be a cosponsor, an original cosponsor, of the gentleman from Connecticut, Ms. DELAURO's, bill to deal with the problem.

As she pointed out, she is trying to address this problem. But, unfortunately, the Republican leadership, in their Medicare bill, which we are going to vote on, I understand, this Thursday, does not. In fact, Speaker GINGRICH's proposal, the Republican leadership proposal on Medicare actually makes the problem of waste, fraud, and abuse in the Medicare Program seriously worse.

The reason for that is, essentially what the Republican leadership is doing with this Medicare bill is trying to achieve savings by cutting Medicare to provide money for a tax cut primarily for the well-to-do. So their concern about problems dealing with waste, fraud, and abuse is really relatively minor in the overall bill that they have and that they will bring before the House.

I am concerned, Mr. Speaker, because we had a hearing, we were not allowed a hearing in the Committee on Commerce, which I sit on, to actually deal with the Republican Medicare proposal, but we decided that we would have our own hearing. And the day after the bill was first presented to us last week, we had our own Democratic hearing on Medicare. Interestingly enough, a number of representatives from the various Federal agencies that go after those who abuse the Medicare System, or commit fraud on the Medicare System, testified to the problems that exist in this bill with fraud and abuse.

Essentially, Mr. Speaker, what they say is that the Medicare restructuring proposed by Speaker GINGRICH and the Republican leadership actually weakens the Government's ability to weed out bad practices and Medicare scams. Over the course of 7 years, $126 billion could be saved by reducing fraud and abuse, but the GOP bill makes the existing civil monetary penalties and the antikickback laws considerably more lenient. According to the inspector general of the Department of Health and Human Services, the Medicare restructuring legislation by the Republicans would substantially increase the Government's burden of proof in cases under the Medicare-Medicaid antikickback statute. And although a fund would be created to direct money recovered from wrongdoers, this fund would not go to further law enforcement efforts.

Now, just to put this in perspective, here we are, pursuant to this Republican proposal, squeezing every last dime or nickel out of the Medicare Program with these spending caps that limit how much can be spent on Medicare, and in the context of that, with our health care system and the quality of our health care system significantly declining because of these cuts, we are now, instead of addressing fraud and abuse and trying to save some more money there, actually making it easier for fraud and abuse to take place.

Mr. Speaker, I think one of the speakers mentioned that the Congressional Budget Office actually estimated that over the 7 years of this Republican Medicare Program, the regulatory relief would actually incur an additional expense of $1.1 billion. In other words, it would cost us another billion dollars or more in this Medicare Program because of the relaxation of the laws that deal with fraud and abuse.

Now, I just want to just give some brief statements that were made by June Gibbs Brown, the inspector general of the U.S. Department of Health and Human Services, at our Commerce alternative hearing on October 3, because she basically specifies why it is true that this Republican bill will cripple efforts of the Federal and State law enforcement agencies to control fraud and abuse in the Medicare system.

She says, ''We believe that H.R. 2425 contains several provisions which would seriously erode our ability to address Medicare and Medicaid fraud and abuse.''

Here are some of the examples she cites. ''The bill would make the existing civil monetary penalty and antikickback laws considerably more lenient.'' She goes on to say, ''The bill would relieve providers of the legal duty to use reasonable diligence for ensuring that the claims they submit to Medicare and Medicaid are true and accurate. This will have the effect of increasing the government's burden of proof in cases under the civil monetary penalties law. In an era where there is great concern about fraud and abuse in the Medicare and Medicaid Programs, it would not be appropriate to relieve providers of the duty to use reasonable diligence to ensure that their claims for payment are truthful and accurate.''

She then says, ''The bill would substantially increase the government's burden of proof in cases under the Medicare-Medicaid antikickback statutes. For the vast majority of present-day kickback schemes, the proposed legislation would place an insurmountable burden of proof on the government.''

She then says, ''The bill would create new exemptions to the Medicare-Medicaid antikickback statute, which could be readily exploited by those who wish to pay rewards or incentives to physicians for the referral of patients.''

But worst of all, Mr. Speaker, even though the bill creates a fund for directing moneys recovered from wrongdoers, the moneys do not go to the enforcement agencies within the Government to continue their efforts to try to stop fraud and abuse. It is incredible to me, Mr. Speaker, that in all the talk about Medicare, that this is what we have in this Republican bill.

O.J. SIMPSON IS GUILTY

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California [Mr. DORNAN] is recognized for 5 minutes.

Mr. DORNAN. Mr. Speaker, I said earlier during someone else's 5-minute special order that I was going to discuss the O.J. Simpson case. I used to represent, for 6 years, the precinct in Los Angeles, the real estate name is Brentwood, CA, where Nicole Simpson had her throat slashed to her spine, and where young Ron Goldman, doing a simple act of kindness, bringing over a pair of reading glasses belonging to Nicole Simpson's mother, then stumbled on to a situation where he yelled either hey, hey, hey or hey, O.J.

The word on the streets of Brentwood, in Los Angeles, from the lawyer of the Goldman family is that one of the defense witnesses lied on the stand.

□ 1815

That he actually told all of his friends that, ''O.J. is going to kiss me if he beats this,'' and that he actually physically saw O.J. Whether that is true remains to be seen. This is somebody who should be polygraphed, should be arrested for perjury, if in fact he told all of his friends that he heard Goldman say, ''Hey, O.J.'', which means he gave his life beyond common courtesy as a Good Samaritan in trying to interfere into what he thought was a beating, until he saw the flash of the knife in the moonlight. I believe that Ron Goldman, at age 25, did die as a hero.

Mr. Speaker, in these short few minutes I want to discuss what I would like to do in an hour special order. If this truly was the double murder or the trial of the century, then it should be discussed on the floor of this, the world's most important legislative body, this Knesset, this House of Commons, this Duma. This House should discuss this issue.

Last night I watched an hour on the murder of Stanford White, the New York architect, on the roof garden of Madison Square Garden which he designed. If that was the trial of the century, and it was only 6 years into the century, or the Lindburgh trial, when I was an infant, was the trial of a century, and this has eclipsed all of that; if more people were aware of the O.J. murder than the atrocity of the bombing in Oklahoma City, or just about anything other than the assassination of President Kennedy or Pearl Harbor, for those of us old enough to remember that, then it should be discussed on this floor.

In this brief, 5-minute introduction to what I intend to do here for an hour, let me say three things. One, of course, O.J. Simpson did it. Of course he did it. Of course the jury did not hear Nicole's statements, because it was hearsay, to several friends. ''He will kill me and he will get away with it. He will O.J. his way out of it. He thinks he is above the law.''

O.J. Simpson is now called the butcher of Brentwood, my former area that I raised five of my children in. Two of my children came home from the hospital to a little house on Chenault three short blocks from the murder scene. Of course he did it.

No. 2, Mr. Speaker, I am going to, with my last breath, defend cameras in the courtroom, because about 50 million people in this country became the 13th juror. They knew more than the alternates did. We must never sequester human beings like this again. They feel they are locked up with less contact with the outside world than Simpson, so of course they felt they were angry with the State. But we must keep the cameras in the courtroom or we would not have know more evidence than the jury itself knows.

No. 3, we must reopen this case. I said this to Mr. Garcetti. I said this to my friend, Sheriff Sherwin Block. And I have said it to the detectives, the prime detectives, one of the trio of detectives that handled most of the evidence. And he said to me on the phone last week, ''Congressman, we had gobs of evidence we did not use.''

How can Garcetti stamp his foot like a petulant child, when a third of this country believes O.J. Simpson was not just not found guilty, not that he was acquitted, but that he is innocent. You cannot leave a third of this country in a fog that a murderer or double killers, maybe more than one, Colombian necklacing drug lords are out there going to terrorize some other family.

We must put this to rest. And here is what I told the detectives and in 4 short minutes, they bought my case. Reopen it. Take Johnny Cochran and Simpson at his word and go look for the killer or killers. Let us reinterview everybody that was interviewed in this case and then a second and a third tier of potential witnesses.

Go over every speck of evidence. It is locked up. Play one lab in this country off against the other. And then come out with a paper or report 6 months or a year from now. And those of us who were the 13th jurors who followed this trial know what the verdict will be. It was the butcher of Brentwood. Mr. Simpson, who if he had any decency, would not ruin his children's lives. He slaughtered their mother. He would go to Mexico, or some foreign country, and get out of our face.

He is shocked that we are not groveling and accepting him back. He told the gentleman from California [Mr. DREIER], on the Tuesday before the murder, that he voted for Bush and that he told that to Clinton's face when they played golf.

I will do this in a 60-minute special order, Mr. Speaker. But let me close on this line. As I told the Presidential candidates in New Hampshire, that Republican millionaires who voted for Bush are more a jury of his peers and they would have found him guilty.

These poor, emotionally distraught jurors were not his peers. Not his peers. He did it. He simply did it, and he has not gotten away with it yet; not in the court of public opinion.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 2259, DISAPPROVAL OF CERTAIN SENTENCING GUIDELINE AMENDMENTS

Ms. PRYCE, from the Committee on Rules, submitted a privileged report (Rept. No. 104–279) on the resolution (H. Res. 237) providing for the consideration of the bill (H.R. 2259) to disapprove certain sentencing guideline amendments, which was referred to the House Calendar and ordered to be printed.

AMERICANS SHOULD PAY ATTENTION TO THE REPUBLICAN MEDICARE REFORM AGENDA

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Illinois [Mr. DURBIN] is recognized for 5 minutes.

Mr. DURBIN. Mr. Speaker, there are many items and subjects debated on the floor of the House, as the previous speaker indicated, from the O.J. Simpson trial to some items that are considered to be very parochial, very regional, very specific.

But there will be a debate on the floor of the House this week which I am afraid has not caught the attention of the American people. The reason I have this fear is because of the gravity and importance of this debate, not only to tens of millions of senior citizens across America, but to all of their families as well.

You can measure the importance of an item in the U.S. House of Representatives by the time we dedicate to that item, in most cases, but not when it comes to this Gingrich Medicare reform. Take a look at this chart as an indication of the time that we have spent in committee hearing on the Medicare reform plan of NEWT GINGRICH.

Well, we spent 10 days looking into Ruby Ridge. We spent 10 days looking into Waco. We have spent 28 days of committee hearings on Whitewater. And how many days have we spent on a $270 billion cut in Medicare? Look closely. One. One day.

The fact of the matter is that even as of this weekend, we are just learning what is included in this bill; a bill which will literally affect every family in America.

My mother is 86 years old. She lives by herself. She has had some medical problems. Thank goodness for Medicare. It's been there when she needed it, and that story is told over and over again. She is happy, but equally important, her family is happy.

As her son, and my brothers, we are all very content that she is under Medicare and has quality health care available to her and a quality of life, which was not around 30 years ago.

So, the Republicans come to the floor and say, We are just trying to preserve Medicare. Well, excuse me if I am skeptical. Medicare was created by the Democrats. A person like BOB DOLE voted against the Medicare plan when it was originally proposed, and many Republicans did as well.

This plan for Medicare has been in place for 30 years, a creation of the Democrats, has worked and worked well. We fear, many of us on the Democratic side of the aisle, that the Gingrich Medicare reform plan is a disaster.

Mr. Speaker, I think the Republicans know it as well. They will not bring it out in the light of day. They will not let us see the details of it. They will not let us have committee hearings. They will not even let us offer but one amendment, one substitute. They are talking about maybe 2 hours of debate on the floor of the House for something that could literally affect American families for decades to come.

Let me tell my colleagues several of the things they should know about it. The Republicans want to cut $270 billion out of Medicare spending. They say that is to save Medicare. That is not what the trustees say.

The trustees say we need to reduce spending by $90 billion, one-third of the amount. Why did they triple the cuts to increase premiums for seniors, to reduce the services available? They need the money for other purposes, and the purposes are very clear. They want to create a tax-break package. A package which, frankly, goes way beyond what working families need.

It is a tax-break package primarily for the wealthiest people in this country: $245 billion dollars. Nothing new. This is the old Republican philosophy. The big business philosophy. The trickle-down philosophy. If you give enough money to the wealthiest people in this country, the Republicans believe that somehow it will eventually get down to working families.

Well, I applaud them for their consistency, even though they have been proven wrong historically and economically. But here they go again. To find the money for it, they want to cut Medicare.

The other thing that troubles me greatly is if you talk to people who receive Medicare payments, the providers, you will find that by and large they are honest and ethical people who are working hard to provide good quality health care, and God bless them for their hard work.

But they will also acknowledge that there are a lot of wrongdoers as well. One to two percent of the people who turn in bills to Medicare are frankly trying to rip-off the Government through fraud and waste and abuse. We know it and we know it costs us dearly.

We estimate 10 percent of all Medicare billing each year is fraudulent; $18 billion lost that should be spent to help people and reduce our deficit. We have had some tough laws on the books. They should get tougher. But know what? The Gingrich Republican approach on Medicare reform lightens the load; makes it harder to prove fraud on the part of those who would try to rip-off the system.

They say it is a sweetheart deal which the Speaker cut with some of the interest groups. I do not know if it is or not, but the bottom line is the Federal prosecutors who have looked at the Republican Medicare reform plan have come to the conclusion that it is going to make it tougher to go after the wrongdoers. That is not fair and it is not fair to the seniors and it is not fair to the taxpayers.

Mr. Speaker, I hope the people of the United States will tune into this debate this week. The Republicans have tried to keep it under wraps. Now it is time to bring it out into the light of day and make sure America knows what is in store for them if these Gingrich Medicare reform plans go through.

MEDICARE REFORM SHOULD ROOT OUT FRAUD AND ABUSE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio [Mr. BROWN] is recognized for 5 minutes.

Mr. BROWN of Ohio. Mr. Speaker, I have conducted numerous town meetings and hearings in my district on Medicare. As my friend, the gentleman from Illinois [Mr. DURBIN], just said, unfortunately, hearings have not taken place in this institution in this body for the public to hear them.

But at these hearings which I have conducted, and in town meetings, I have heard over and over again people's anger about the $270 billion in Medicare cuts in order to pay for tax breaks for the wealthiest citizens in this country, the people who need them the least.

But what also concerns me and what troubles me is something else that I hear at these hearings, these town meetings, and that is people believe there is a good deal of fraud in the Medicare system. That fraud is something we have to aggressively pursue and prosecute and root out and do something about.

That is why it particularly troubles me and concerned me to see an article in USA Today, an editorial on Friday, and the headline reads, ''Medicare Reform Invites Doctors To Bend the Rules. Easing Limits on Physicians' Self-Referral Is Bound To Cost the Medicare Program Billions of Dollars That It Can't Afford.''

USA Today goes on to say:

No wonder the American Medical Association has signed on to Medicare reform, with the deal that they made with Republican leadership. The Republican Medicare bill actually promotes fraud, waste and abuse in several areas, particularly in its weakening of the ban on physician referral of Medicare and Medicaid patients for tests and treatment in places where the doctor has a financial interest.

Another newspaper talking about this agreement made between Republican leadership and the American Medical Association says:

Regrettably the Speaker's concessions made an already bad Medicare bill substantially worse. The Gingrich bill was never designed to give the elderly high-quality health care. It is less likely to do so now.

Unfortunately, this piece of legislation, this Medicare bill which the American people have not been able to find out much about, because there have not been hearings in this institution, that Gingrich Medicare bill eliminates fraud by legalizing it. It simply makes things legal that were not legal before. It encourages more fraud, instead of less.

Not too long ago, about a week ago, in the Committee on Commerce, a committee on which I sit, the committee that heard the Medicare and Medicaid bills. Rather, did not really hear them, because we were not allowed to have hearings, but a committee that discussed Medicare and Medicaid and allowed amendments and we talked about the bill, my colleague, the gentleman from Michigan [Mr. STUPAK], offered a substitute bill that would have, instead of cutting $270 billion in Medicare in order to give tax breaks to the wealthiest citizens in this country, would have gone directly after fraud and abuse in the Medicare program.

Unfortunately the chairman of the committee ruled the Stupak substitute out of order. We were not able to debate this or discuss this and we were not allowed to vote for a bill, instead of $270 billion in cuts to Medicare beneficiaries and to give tax breaks to the wealthiest citizen, instead it would have devoted resources to rooting out fraud.

☐ 1830

The Office of Inspector General reports that every year for every $1 spent on going after fraud and investigators and inspectors and prosecutors, that $80 is recovered that can go back into the Medicare system. So why are we cutting $270 billion out of Medicare to pay for tax breaks for the wealthy and why are we cutting back on the enforcers and the investigators and the prosecutors and the people that for every dollar spent can recover $80?

I think it goes back to that editorial in USA Today about the arrangement that the American Medical Association made with the Republican leadership in this House. It is troubling to me that we could save much more than even the trustees said. They said that we need to cut $89 billion in order to keep Medicare strong for the next decade or

so. We are saying that pursuing fraud the way that we can can save almost $100 billion. The inspector general says that 10 percent of Medicare moneys are fraudulent, that over the space of the next 7 years, $200 billion will be lost to fraud. If we can go after that fraud, whether it is durable medical equipment reform, whether it is putting in civil penalties for kickbacks, whether it is strengthening conflict of interest rules, whether it is grand jury disclosure, increased subpoena authority, all these together, if we can only save half, if we can only recover half of the fraud in the Medicare system, we will have more than enough to meet the trustees' recommendation, to keep Medicare strong for the next 10 years.

Mr. Speaker, it simply does not make sense to make these cuts in Medicare to give tax breaks to the wealthy. We should go after fraud aggressively. We should crack down on fraud, not cut senior citizens' ability to get health care.

MEDICARE DECEPTION

The SPEAKER pro tempore (Mr. GUTKNECHT). Under the Speaker's announced policy of May 12, 1995, the gentleman from Washington [Mr. MCDERMOTT] is recognized for 60 minutes as the designee of the minority leader.

Mr. MCDERMOTT. Mr. Speaker, in these Halls in 2 days we will have a vote on H.R. 2425. It is the Republicans' plan to slash Medicare by $270 billion over the next 7 years. Now, if you believe the Republican rhetoric, every one of us here would think that these drastic cuts are necessary to prevent the Medicare program from going bankrupt. Nothing could be further from the truth. These cuts have little to do with saving Medicare or the part A trust fund.

Let me say, we throw terms around in this House that are often not well understood by the public. Medicare is divided into two pieces: part A, which is the hospital payments, and part B, which is the payments to doctors and other providers of services to the elderly. These cuts have little to do with saving part A.

The Republicans are cutting $270 billion from Medicare because they want to use that money to offset the $245 billion in tax cuts for wealthy Americans.

Now, ask yourself this: If the Republicans were so concerned about the impending bankruptcy of the Medicare trust fund, how come they never mentioned it before November 1994? It is ironic, when you think about it, that with all of the Republican rhetoric about saving the trust fund, the only action they took this year in 1995 was to approve a tax provision in the Contract on America which takes money out of the hospital trust fund through a reduction in the amount of Social Security taxes paid. Over $36 billion would be removed from the fund over the next 7 years as a result of that legislation that has already passed this floor.

You heard me right. The first thing the Republicans did was to take $36 billion out of the trust fund. They will stand out here and say we have to put this money into the trust fund, but the first thing they did was to take it out.

Furthermore, the issue of the insolvency of the part A trust fund has simply nothing to do with Medicare's supplementary insurance that is part B, the report of the part B trustees, which you never hear mentioned on this floor, is that part B is actuarially sound. It is absolutely financed.

Therefore, if you are making cuts in Medicare which are being made solely to save part A, the hospital part, there is no need to take $140 billion in cuts out of part B. Almost $54 billion is in increased premiums to seniors that they pay each month. That is not necessary to save part A.

Not 1 cent of the money cut from part B in their proposal, which you will see on Thursday, will go into part A. The dollars go into the general fund to take care of the tax cuts which will follow.

As a result of the increasing public opposition to these drastic cuts in Medicare, the Republicans had to do something, which is saying, you are just shifting the money around. So they said, we will create a lockbox which they claim will sever the connection between the Medicare savings and the tax cut. They are going to try and divide it.

One of the reasons why we are voting on Medicare this week and the tax breaks next week is they do not want you to think there is any connection. This lockbox is simply an illusion. It is really a return to the kind of smoke and mirrors budget gimmickry that they hope will fool the American people.

The Republicans think that the American people are stupid. They want us to believe that by depositing the money they cut from Medicare into a separate account, they can prove that the Medicare cuts will not pay for tax breaks.

Now, we all know that money is green. The term we use around here is fungible. You can use it here, you can use it there. It makes absolutely no difference which government account the money is put into or taken out of. The Government must pay its bills, and it does not matter which checking account it is in. You can have a bunch of different checking accounts. It is still government money. It comes from taxes. They are just simply trying to hide it.

The bottom line is that the Republican lockbox is just a new Federal bank account. The Republican Medicare bill and the rhetoric that makes it sound as if no spending is allowed out of the lockbox is simply an illusion.

Their bill allows borrowing. They put it into the lockbox. You cannot spend it, they say, but you can borrow it. In fact, it requires the lockbox to lend money to the Department of the Treasury.

Coincidentally, of course, the Treasury Department needs these funds because of the Republican tax break. The American people need to know that the money from the cuts in Medicare not only goes into the new lockbox, but the money goes right through the lockbox and into the pockets of the wealthiest taxpayers who will benefit from the Republican tax cut. Over half of that $245 billion in tax breaks goes to people making more than $100,000.

Now, to further mislead the American people, the Republican leadership has suddenly decided that this Medicare legislation will have a separate vote in the House of Representatives. The Medicare legislation will be considered separate from reconciliation. On Thursday we do Medicare. Next week or sometime thereafter, who knows, we will have the reconciliation bill which will have all the tax breaks in it, and the Medicare legislation will be incorporated by reference.

That is a fancy term we use in the Congress to say, what happened a few days ago applies today. They will say they are totally disconnected, but in fact the bill contains an incorporation by reference.

Without that phrase, without that incorporation by reference, the Congressional Budget Office would not be able to count the Medicare cuts in determining whether the reconciliation bill includes enough deficit reduction to allow the $245 billion in tax breaks to go forward.

The Republican leadership has created a perfect scenario for spin control and deception. They can argue that the $270 billion in Medicare cuts are separate from the $245 billion in tax breaks while at the same time counting the savings from Medicare toward the amounts needed to balance the budget.

Now, you can get as fancy parliamentarily as you want to here, but no amount of procedural vote wrangling or accounting gimmicks can hide the fact that the $270 billion in Medicare cuts are tied to the $245 billion in tax breaks. The numbers match.

In addition to creating this lockbox, which could be raided at any time, the Republican bill does not extend the solvency of the part A hospital trust fund any longer than the Democratic substitute bill but it slashes Medicare by three times as much. The Republicans cannot hide this any longer.

Although they claim that their plan will extend the solvency of part A until 2014, and you will hear this on Thursday, you will hear 2014, it is not true. The net impact of the Republican plan is to extend the solvency of the hospital trust fund, part A, until 2006 at a cost of $270 billion.

I dropped in a bill, H.R. 2422, which also extends the Medicare trust fund until 2006, but it costs $90 billion, not $270 billion, $90 billion.

Four of the Medicare trustees and the HCFA Administrator—HCFA is

Health Care Financing Administration, for those of you who have forgotten—the HCFA Administrator, who runs this thing, says that the reductions in part A are approximately $89 billion and would be enough to ensure solvency to 2006.

The Republicans can only achieve $270 billion in cuts by drastically reducing benefits to seniors and shifting the costs onto beneficiaries; that means senior citizens and their families. The Republicans want to reduce the Medicare Program to a worthless shell.

Medicare that seniors know today will exist in name only while providing no real health care or economic security to the beneficiaries and their families. People will pay more and get less.

Despite the $270 billion in Medicare cuts, the Republican bill does nothing to solve the problem of baby boomers entering the Medicare Program in 2010.

Now, lots of people throw this term baby boomers around. I am not always sure they understand what we mean by that. If you were born after 1945, you will be 65 in 2010, and you come into Medicare. Anybody born after 1945 is a baby boomer. They are the people who come into the program in 2010.

On December 27, 1995, I introduced a bill, the Medicare Security Act, which extends the solvency of the Medicare trust fund until 2006 and creates a bipartisan commission to deal with this problem of the baby boomers.

In response to the introduction of my alternative Medicare bills, the Committee on Ways and Means chairman, the gentleman from Texas [Mr. ARCHER], stated in a press release: ''Any proposal that fails to save Medicare until the eve of the baby boom retirement must be considered a failure.''

Well, Mr. Speaker, the chairman by his own standard failed in his Medicare bill. According to the actuaries for the Medicare trust fund, the Republican plan would extend the life of the hospital trust fund, part A, through the third quarter of calendar year 2006. That is a quote from a letter dated 11 October 1995 to the gentleman from Florida [Mr. GIBBONS] from the HCFA Administrator, Bruce Vladeck, based on data from the Medicare actuaries.

The year 2006 is 5 years before the first baby boomers begin to retire in 2011 and 8 years shorter than the Republican claims of solvency until 2014.

In addition to cutting three times more than is needed for Medicare to stabilize the part A trust fund until 2006, the Republican bill is loaded with sweeteners for various interest groups to silence any opposition.

As a doctor, it is troubling to me to see members of the American Medical Association put their own interests ahead of their patients by cutting backroom deals with the Speaker in exchange for their support of the Republican bill. In a bill in which beneficiaries are being asked to contribute $53 billion more, the doctors were negotiating provisions allowing them to create their own health care plans and avoid further reductions in their fees.

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The Republican bill will allow doctors, as well as hospitals, to create doctor-hospital networks to sell health insurance plans directly to Medicare beneficiaries. These new networks will be called provider-sponsored networks or PSN's. It is a new term for you to learn because you are going to hear it endlessly on Thursday. Provider-sponsored networks; that means doctors are out there doing whatever they want with hospitals under special Federal rules which will preempt, which will preempt, override, existing State laws. It will allow the PSN's to operate with lower financial reserve requirements and other standards than are required for HMO's and private insurers. That means the insurance commissioner in the 50 States will not be able to control and regulate what these PSN's are out selling to beneficiaries.

To allow these PSN's to operate immediately, Mr. Speaker, the Medicare plan by the Republicans changes existing antitrust laws and says that the States do not need, the PSN's do not need, State licenses. Clearly, being exempt from existing State regulation will give these PSN's an unfair competitive advantage for doctors and hospitals over existing HMO's. If that was not enough, other giveaways to doctors are limits on medical malpractice awards for pain and suffering to $250,000.

The approach taken by this bill is extremely one-sided and does nothing to protect and promote the legal rights of injured patients. The Republican bill only seeks to protect doctors from full legal and financial accountability for their negligent behavior while restricting the ability of patients and their families to receive fair and adequate compensation.

The list of benefits for doctors goes on, rolling back vital Federal oversight of clinical laboratories in doctor's offices. In other words, doctors can refer to their own laboratories. They eliminate provisions on doctors' self-referral. They provide unwarranted antitrust relief for physicians. They provide the ability to charge Medicare Plus, and that is what they are going to try and push all the seniors into, is Medicare Plus. They are going to allow the doctors to charge higher fees, and they also set a new formula for setting fees in the old traditional Medicare. Mr. Speaker, it is clear that the only interest the American Medical Association has in Medicare is a financial interest for themselves.

The Republican plan also offers beneficiaries some false choices and false promises of security. The Republican plan creates Medicare Plus; I mentioned it earlier. It is a program which is advertised as offering seniors more choice of health care options, but in reality will create divisions and inequalities within Medicare. Medicare Plus will actually force beneficiaries to pay more for less while initiating what I call a death watch for the traditional Medicare Program. Medicare Plus under the Republican plan will be available as an alternative to traditional Medicare fee for service.

Now what is Medicare Plus? Well, it really is managed-care plans, some new types of specifically specially structured health plans such as the PSN's I talked about, medical savings accounts, and health plans offered by qualified associations like the Chamber of Commerce. I do not know; it is not clear in the bill. It is simply there.

Unfortunately for seniors all these new choices for health care are based on a false promise because Medicare Plus, Medicare's contribution to these plans, will be a defined contribution or a fixed amount of money which will be given each year which will decline over time resulting in seniors being able to purchase less and less health insurance. It is right in the bill.

Now what does that mean for seniors? Well, it is pretty simple. It means that an underfunded voucher, they hand you something that will buy for this year what next year will buy you 20 percent less, and this time, instead of the Government sending the voucher to the beneficiary, to the senior, they are going to send it to the health plan.

Under the Republican plan, Mr. Speaker, the total annual growth in the size of vouchers for health care plans is set at 4.7 percent. Now where did that number come from? It came out of the air. There is no basis for that. We expect, and CBO expects, that private health insurance premiums will grow at 7.1 percent. So, if it is growing for everybody else in the society at 7.1 percent, but we are going to only pay 4.7 for seniors under this Medicare Plus, you can see that gradually the buying power of senior citizens is going down by a couple of percent every year. By the time we get to 2002, you will be paying a thousand dollars more out of your pocket if you are a senior citizen buying health care than you are today.

Now that is a rate of 30 percent higher than the Medicare vouchers are allowed to grow. The private sector is still going to grow 30 percent faster than Medicare will be allowed to grow. It does not take a rocket scientist to figure out that the Republican vouchers are putting seniors on a road to second-class health care. The vouchers will quickly buy less and less coverage on their Medicare Plus, and beneficiaries will have to pay the difference, or their families. If you realize that there are more than 3 million widows in this country living on less than $8,000, and you are talking about the year 2002 they are going to have to come up with another grand out of their pocket, you know they cannot do it. Their kids will have to do, if they are lucky to have kids who have the money to do it. Somebody else is going to have to pay for it because these seniors are not going to be able to do it.

Mr. Speaker, the additional out-of-pocket costs which will be paid by seniors makes it clear that the additional choices provided by Medicare Plus do nothing to reduce the health care costs overall. It is an arbitrary 4.7 annual growth limit on vouchers. That saves money to be given for a tax break to the richest Americans.

In addition to having to pay the difference between the value of the voucher and the cost of the benefit package, seniors enrolled in Medicare Plus will also be liable for extra charges by providers trying to compensate for Medicare's declining provider reimbursement rates, so if we cut the doctors what they are paid under Medicare, and you allow the doctors to balance bill, they can get it back out of the senior because we have taken off the protection against balance billing.

These extra charges, as I say, are called balance billing. It is a practice by which providers charge beneficiaries more than Medicare approves. The restrictions in current law on balance billing, which permits no balance billing by hospitals and only limited balance billing by seniors, will not exist for seniors enrolled in the Medicare Plus plan. This is a very important concept. There will be no protection for seniors against these hidden new charges, and doctors will have a financial incentive to no longer see patients in traditional Medicare. If you stay in traditional Medicare, they cannot charge you balance billing. If you go into Medicare Plus, they can get you. Now that is what I call a real revolution.

One of the most egregious examples of waste in this Medicare plan are the Medicare savings accounts which are an option under Medicare Plus. Every legitimate health care expert has agreed that a MSA, medical savings account option, will result in extra costs for the Medicare program and weaken the hospital trust fund. MSA's allow beneficiaries to choose a high-deductible health plan combined with a fixed deposit from the Government into an MSA to cover their routine health care costs.

Let us say the Government gives you $5,000, and you take a thousand of it and buy a $10,000 deductible program. Then you got $4,000 in the plan, and you can use that to cover your routine health costs. If you do not spend anything, you got $4,000 bucks for yourself, and the healthy seniors will do very well on that, but people who have real problems are going to be a problem for the system.

Mr. Speaker, CBO says that the MSA's in this bill will increase, I emphasize increase, Medicare costs by $2.3 billion. It is not a savings mechanism for the system. It is a giveaway to people who opt out of the Medicare system.

Now this money that could have been spent on health care for senior citizens will instead go to the healthiest and wealthiest of seniors. Medicare loses money with MSA's because healthy people will choose the MSA option while Medicare lacks the ability to adjust the MSA payments for the risk factors. Furthermore, the idea that MSA's will protect freedom of choice for seniors is a sham. Once this product, once the MSA's are out there and become widespread, the insurance companies will take over the MSA product, and they will change it to managed care. The result for seniors will be a high-deductible plan with a managed-care product at the end of your deductible.

Mr. Speaker, this is not Medicare reform. It is one of the first steps in the destruction of the traditional Medicare and elimination of the guarantee of health care for all senior citizens.

The impact of $148 billion in cuts to Medicare providers under the Republican plan will create severe hardships in rural areas. It is not just a city problem. We are talking about rural areas where hospitals exist in many cases almost totally on Medicare and Medicaid payments because retired seniors are living out there, and that is what keeps those rural hospitals going. Rural hospitals and clinics already are in financial difficulty, and they will be hard pressed to absorb the reductions mandated by the Republican bill. In addition, the urban hospitals will be forced to accept added reductions and special Medicare payments for uncompensated care. Big-city hospitals take care of a lot of people who come in who do not have any way to pay, and Medicare gives them money to cover that. It is called dish payments, disproportionate share. Those payments are made by Medicare, and, when we cut those out in this bill, those hospitals are going to be in even worse shape.

Now, if all of this was not bad enough, in addition to the $148 billion cut from providers, that is doctors and other people who provide services, the Republican bill includes something called a fail-safe mechanism requiring an additional $37 billion in cuts from providers if Medicare spending does not meet the arbitrary targets set in this budget resolution. What they are admitting here is they do not know how it is going to come out, and just in case it does not work, they will cut another $37 billion out of doctors and whatever with no specificity. You do not know what is going to happen. What will happen to home health care? Who knows. What will happen to nursing visits, Visiting Nurse Association kinds of things? Who knows? That $37 billion is sort of sitting there waiting to take a whack out of these things someplace down the road.

Now this fail-safe mechanism will only affect the traditional fee-for-service Medicare system. Is that fair? Why only the traditional one that people have known, and have lived with and felt secure with? Why not the MedicarePlus? Well, it is pretty obvious. It is simply an assault on the Medicare plan that every senior citizen in this country knows and understands.

Slashing reimbursements to doctors who remain in the traditional fee-for-service system will result in more and more doctors leaving Medicare to join these PSN's, these provider service networks, where they can escape State regulation and charge beneficiaries more.

☐ 1900

Over time, Medicare beneficiaries will find that the Republican Medicare bill will force their family doctors to leave them and join a provider service network.

If you do a survey of seniors and ask them for suggestions on how to control the rate of growth of the Medicare Program, nine out of 10 seniors will respond that the Government needs to crack down on fraud and abuse in the Medicare system. The Republican plan does nothing, nothing to curtail fraud and abuse, and instead, does the exact opposite by weakening the administration's efforts to combat fraud and abuse.

The GAO, that is the Government Accounting Office, they are the people who go in and look and see if the numbers really add up, they estimate that fraud and abuse in the health care industry account for an estimated 10 percent of our yearly private and public health care expenditures. Based on that estimate, fraudulent payments in 1994 amounted to nearly $94 billion in this country. Broken down, that amounts to approximately $258 million a day, or $11 million every single hour.

As the General Accounting Office stated in testimony before the Committee on Ways and Means, Medicare has already begun to address the problem, and actually leads the private sector in health care anti-fraud and abuse efforts. Unfortunately, in spite of all the rhetoric you hear about fraud and abuse, the Republican proposal loosens the rules that outlaws kickbacks and that requires providers to exercise due diligence in submitting accurate and true Medicare claims.

That is not just Democrat rhetoric against the Republican bill. Under the Republicans, the Congressional Budget Office has estimated that the Republican fraud and abuse provisions will cost, cost the Medicare program over $1 billion from 1996 to 2002. That is right. Get it straight. The Republican bill encourages $1 billion in fraud and abuse in the Medicare program. All three of the Federal Government's health law enforcement agencies have spoken out against the Republican plan. It is too bad, in my opinion, that the Republicans are too stubborn to listen to the people who actually enforce the law.

It really is time to focus on the facts. The Republicans are cutting Medicare by $270 billion to pay for unnecessary tax cuts, and they at the same time are starting the death spiral of the traditional Medicare program. My bill, H.R. 2422, the Medicare Security Act, shows

the American people that we can protect the Medicare program without hurting our beneficiaries, or disrupting our health care delivery system.

I would be the last person in this House to dispute the fact that Medicare is growing too rapidly, and its rate of growth needs to be controlled, if we are going to avoid bankrupting the Federal Government. However we do not need to cut $270 billion from the Medicare program over the next 7 years. Cuts of this magnitude do nothing to save the Medicare program, or extend the solvency of the part A hospital trust fund any longer than is extended by my bill to 2006. Medicare is being cut for one reason and one reason only: That is, to balance the budget and pay for the tax cuts in the amount of $245 billion.

My bill shows Medicare spending by $90 billion over the next 7 years, which would keep the part A solvent until 2006. This gives the Congress and the President 10 years to fix the problem of the baby boomers entering the Medicare system, without imposing any hidden costs on seniors or impeding their access to care.

As a reasonable alternative, my bill cuts $67 billion from Medicare part A and $23 billion from part B. All of the part B savings go into Part A to make it solvent. These cuts are basically technical adjustments that the health care delivery system can absorb and that will preserve the same level of Medicare coverage and benefits that beneficiaries have today, which is quite different than the Republican bill. Equally important, my bill ensures that the savings in the Medicare program will not create profound disruptions in the health care delivery system, or our teaching hospitals, or access to quality care by our seniors.

My approach avoids the substantial increases in both the cost of private insurance and the number of uninsured persons which the Republican plan guarantees. The cuts in my bill are distributed throughout the health care system in an equitable manner to doctors, hospitals, home health agencies, and skilled nursing facilities. In my bill, there are no increased costs to beneficiaries, and adjustments to provider reimbursements have been specifically tailored to protect the basic elements of our health care infrastructure.

The Medicare Security Act will not place any additional financial burdens on our elderly poor or their families. You have to understand that fully 83 percent of Medicare expenditures are for beneficiaries in this country, senior citizens in this country, with incomes of less than $25,000. We are talking about people who are living a comfortable life, they are not in poverty, but they are not rolling in money. This is a program that protects the basic American infrastructure that has built this country, people that paid their way, that made this country what it is.

Beneficiary payments and copayments should be increased only as a last resort, because these seniors simply cannot afford a doubling of the part B premium, which is what is anticipated under the Republican plan. Their part B premium, that is, for the doctors, already rises from $46 a month to $87 a month by the year 2002.

Under my plan, the premiums, as they have grown each year a little bit, will be increased to $58 per month. That is a savings of $30 a month for senior citizens. The real problem, and I think the thing that has been missed in all this debate, because most people walk around thinking this is a senior citizens issue, it really is not a senior citizens issue only. It is partly theirs, but it really is also everyone else's in the population, because the problem for Medicare starts in 2010, when the baby boomers enter the program.

Many young people in this country do not believe that Medicare will be there for them when they reach that age. They say, ''Why should I pay for Medicare, because it is not going to be there when I get to be 65.'' That is a legitimate concern. The Republicans' proposal to slash Medicare does nothing to solve that problem. For that reason, my bill, like the Republican bill, creates a bipartisan commission to specifically address the changes needed in Medicare and in health care coverage and finance generally to accommodate those aging baby boomers in 2010.

You may say, ''Why another commission?'' In 1983, this House was worried about Social Security. There were thoughts it was going to be insolvent. It would not be there at some point in the future. They formed a commission, made recommendations to this House, we changed some of the laws, and it is now solvent to about 2040. It is that proposal that we have before this House in terms of a bipartisan commission to facilitate the national debate, which is necessary to determine what kind of Medicare program we want for older Americans, and whether or not we as a Nation are willing to pay for that program.

We have to make a decision again that was made in 1965. The reason we have to make it now is that we have been so successful. Medicare has been successful. People are living longer. They are living more productive lives. We have more ways in which we can extend life and make life meaningful, and it is costing more. We have to have that debate again. Are we willing to do that for the rest of the society when they get to be 65, and are we willing to pay for it?

This blue ribbon commission created by my bill will be charged with the responsibility of building a national consensus on the future of Medicare. This commission will make recommendations to the Congress by January 1, 1998. That is 8 years before any future Medicare collapse in 2006. It is clearly possible for them to do that over the next 2 years, and they should do it. I firmly believe that this commission is the most important part of the bill, and the most important part of this Medicare debate.

Before making radical changes in the structure of Medicare, let us have an open and honest debate about what we can do to fix Medicare without destroying it. Changes in Medicare of the magnitude proposed by the Republicans should not be rammed through the House of Representatives after one day of floor debate. Four hours and we are going to ram it out of here.

We had not one day of testimony before the Committee on Ways and Means on the proposal that was voted out last week. We had many days talking about what the problem was. You will hear people say, ''We had days and days of hearings on it;'' yes, describing the problem, but not a single day was spent in careful examination, with people coming in from the outside to talk about what the effects of their proposal really would be, so we are going to ram something out of here destroying Medicare, and it does not have to happen.

My bill lays down a marker for honesty and simplicity. According to the Congressional Budget Office, this bill and the Republican Medicare bill take the Nation to the same destination, 2006. Fortunately, my bill costs one-third as much, and I believe that is what the House ought to go for. I can see no reason to dismantle Medicare simply for the sake of a tax cut for the wealthiest Americans.

Mr. Speaker, I yield to my colleague, the gentleman from Vermont [Mr. SANDERS].

Mr. SANDERS. Mr. Speaker, I thank the gentleman for yielding to me. I applaud him on his work.

Mr. Speaker, I would remind the gentleman that several years ago we were in discussion about another issue.

Mr. MCDERMOTT. If you are talking about single-payer, I am ready to go.

Mr. SANDERS. At that time we were not talking about making savage cuts in Medicare or making savage cuts in Medicaid. At that time what the gentleman was doing and many other Members of this House, and what I was trying to do, is bring forth a program that would not be cutting programs for the seniors or the low-income people, but in fact, in a cost-effective way, would be guaranteeing health care to every man, woman, and child in this country without out of pocket expense. In fact, it would be providing health care to all of our people without spending any more than we are currently spending. We have come a long way in 2 years. Unfortunately, we have moved rapidly in the wrong direction.

Today, instead of talking about how we are going to cover everybody, what we are talking about is how we are going to throw huge numbers of people off of health insurance altogether.

What I wanted to focus on for a few moments is the impact of the cuts in Medicare and Medicaid on small, rural States like the State of Vermont. As

the gentleman indicated, in terms of the Medicare cuts, we are talking about a $270 billion cut over a 7-year period. In terms of Medicaid, we are talking about a $180 billion cut over 7 years. I want to make a point here that is not made often enough, I think, that the cuts in Medicare and the cuts in Medicaid are only part of an overall attack by the Republican leadership on senior citizens in general. Medicare, yes; Medicaid, yes, cuts. The LIHEAP program, the fuel assistance program that is very important in the cold weather States like Vermont, is being proposed for elimination by the Speaker, the gentleman from Georgia [Mr. GINGRICH], and the other leaders in the House. What that means is that many elderly people throughout this country are going to find it very difficult to pay the fuel bills when the weather gets to be 20 below zero in the State of Vermont.

I would also mention that senior citizen housing, which is very important in the State of Vermont, and I am sure important in Washington State as well, is targeted for no more new construction. In Vermont senior citizen housing is terribly important. I used to be the mayor of Burlington, VT. We had long waiting lists of elderly people who wanted to get into the reasonably inexpensively comfortable senior citizens housing. No more senior citizen housing.

Furthermore, we are talking about the elimination of the RSVP program and other senior citizen programs, so we should look at the cuts in Medicare and Medicaid within a broader scope, and that is part of a savage attack on the needs of elderly people.

The gentleman is correct when he talks about the fact that the real reason behind these terrible cuts in Medicare and also in Medicaid have far more to do with tax breaks for the wealthy than they do with protecting the Medicare system.

The Republican leadership is proposing a $245 billion tax break over a 7-year period, and much of those tax breaks are going to the wealthiest people in America. In addition to the individual tax breaks, we should reemphasize the point, reiterate the point, that the Republicans are proposing to repeal the minimum corporate tax, so on one hand we are going to be telling elderly people that they must pay more for health care when they cannot afford it. On the other hand, we are telling the largest corporations in America who make billions of dollars in profits, whose profits now are at an all-time high, that they are not going to have to pay any taxes at all.

□ 1915

Furthermore, we are talking about increases in military spending, more money for B–2 bombers, more money for star wars.

Furthermore, we are talking about the maintenance of a system which provides $125 billion a year in corporate welfare.

Now, why, in God's name, are we cutting back on Medicare, cutting back on Medicaid, but not making significant cuts in corporate welfare, which is tax breaks for the wealthy and subsidies for large corporations.

In my State of Vermont, as a result of the Republican Medicare cuts, some 80,000 senior citizens and disabled Vermonters will be paying higher premiums for a weakened Medicare system. In Vermont, these cuts represent a $356 million loss of revenue. As a result of the Republican proposal, Medicare part B premiums will rise from the current cost of $46.10 a month to $87 per month in the year 2002. Under current law, the part B premiums would have increased to $61 a month.

In other words, the Republican proposal will cost Vermont senior citizens and disabled people, by the year 2002, $312 a year more in part B premiums.

What I would point out is that there may be some people who are not senior citizens who think, well, Medicare is providing great coverage right now. Is that not great? As I know the gentleman from Washington knows, that is not the case. In my State of Vermont, I talk to many seniors who have Medicare who today cannot afford the high cost of prescriptions. They cannot afford to pay their fuel bills. They are hurting, despite Medicare, as the gentleman, I think, knows. Elderly people are paying a larger percentage of their fixed incomes out of their own pockets for health care today than before Medicare because of the escalating cost of Medicare in America. So with Medicare today untouched, many of the elderly are having a hard time affording their health care needs. With these cuts, there will be an absolute disaster.

I also want to say a word on the issue of Medicaid. Medicaid, of course, applies to many senior citizens who use Medicaid for long-term care in nursing homes, but it also applies to the low-income disabled, and it applies to low-income children, and I would hope that the American people would take a deep breath and take a look at the values of a society which say, yes, more money for star wars, more money for B–2 bombers, more money for corporate welfare, more money for tax breaks for the rich, but we are going to go after the weakest and most vulnerable people in our society, low-income elderly people, low-income disabled people, and low-income children. What a set of values. It does not make a whole lot of sense to me.

I would also point out that in the State of Vermont and all over the country, when these cuts come to Medicaid and these cuts come to Medicare, many, many middle-class families today that are struggling with declining incomes are suddenly going to wake up and find out that they are going to have to pay more out of their limited incomes to take care of their parents who are in senior citizen nursing homes or wherever, because Medicaid will not be covering those needs.

I would also point out that in rural States these Medicaid cuts are going to be very devastating, and the Medicare cuts as well, for our hospitals. We do not have huge hospitals. Many of the hospitals in the State of Vermont are small, rural hospitals which today are barely hanging in, and when we appreciate the fact that in the State of Vermont, a rural State, 55 percent on average, 55 percent of the revenue that comes into the hospitals comes from Medicare or Medicaid, there is no debate that in rural America and in rural Vermont, many of the hospitals, we have hospitals, Central Vermont Hospital, 60 percent of the revenue comes from Medicare and Medicaid, Grace College, 66 percent, North Country Hospital, 64 percent, Northeastern, 59 percent, Northwestern, 59 percent, Springfield Hospital, 61 percent, Mt. Ascutney, 68 percent of their revenues coming in from Medicare and Medicaid. How do these hospitals continue if there are savage cuts in those programs?

The last point I want to make, and the gentleman from Washington has already make this point, is we are talking about drastic cuts in programs which are going to affect tens of millions of Americans all over this country. The calls coming into my office now are primarily calls which say, ''Bernie, do not cut Medicare. Do not Medicaid. We just can't survive if those programs are cut.'' I am sure that is true of most of the Members of this House.

One would think, one might think that when we are talking about drastic cuts in programs which affect the lives of tens and tens of millions of American people, there would be very long, serious debates in committee and on the floor of this House, that these debates would go on day after day, we would hear discussion from the most knowledgeable people in America as well as from the senior citizens and the low-income people who are going to be impacted. But as the gentleman has already points out, that debate is very, very limited, and we know the reason why.

I think the Republican leadership understands that the more the American people learn about their proposals, and the polls all indicate this, the less support there is for that. So they are trying to push these things through and in, I think, a very unfair and undemocratic way.

I thank the gentleman from Washington very much for the opportunity, to say a few words.

Mr. McDERMOTT. Your last point reminds me of the fact that Seattle is playing, tonight, baseball against the Cleveland Indians. The pitcher on the mound is a guy named Randy Johnson, who throws about a 95-mile-an-hour fast ball. The Republicans are throwing a 95-mile-an-hour fast ball past the American people. They want this jammed through here so fast that nobody can really figure it out. That is

really what this is all about, only they do not understand it. The American people have seen that pitch before, and they are going to hang in there and clobber it. I hope the Cleveland Indians cannot clobber Randy Johnson tonight.

Mr. SANDERS. I would remind the gentleman a couple of years ago we did a poll in the State of Vermont. We asked Vermonters if, given a choice between raising taxes on upper-income people or cutting Medicare, what would they prefer. Overwhelmingly, people said if the choice is cutting Medicare or raising taxes on upper-income folks, we should raise taxes on upper-income folks.

What would be the poll results if we said should we lower taxes on the richest people in America and cut Medicare? I do not know of 5 percent of the population who thinks that is a good idea. That is why they want to move this thing through the House so very fast.

Mr. McDERMOTT. Absolutely. I thank the gentleman very much.

THE PROGRAM TO SAVE MEDICARE

The SPEAKER pro tempore (Mr. GUTKNECHT). Under the Speaker's announced policy of May 12, 1995, the gentleman from Florida [Mr. MILLER] is recognized for 60 minutes as the designee of the majority leader.

Mr. MILLER of Florida. Mr. Speaker, we are finally coming down to the time we are actually going to be able to vote on the Medicare Program. I am excited about the fact that we are finally going to have the chance to really vote and pass a good Medicare Program that saves the Medicare Program. That is something we are proud of over on this side of the aisle.

All we hear from the other side of the aisle, all we hear are fear and scare tactics. You know, the saying is Medicare or mediscare. All we are hearing is, ''Oh, my gosh, what are we going to do?''

Listen to the truth. We are saving Medicare. It is going to become a better program. You know, Medicare is a very, very important program. It is very important for me in my district in Florida. I have got more seniors than any congressional district in the United States. So I have large numbers of seniors. It is very important for jobs in my district. It is the largest employer in my district. My mother, my 86-year-old mother, is on Medicare, and my in-laws, whom I just lost recently, were on Medicare. It is very important to me personally. So we have to save Medicare. No one wants to get rid of Medicare.

The simple question is, and I do not understand what they are screaming about, Medicare should not be a partisan issue. Everybody on both sides of the aisle agree Medicare is going bankrupt. We do not disagree with that issue, and Medicare, we need to save it. We agree on that.

We have the plan. We have the only plan, actually. The Democrats are saying they want to save Medicare, too. So we are all in agreement on that. All we want to do is offer choices.

What is wrong with offering choices? The previous speakers said we do not want to have these choices; this is a bad choice, that is a bad choice. What is wrong with choices? As a Federal employee, I have choice. You have choice, I say to the gentleman from Arizona [Mr. HAYWORTH]. You have a choice when you choose next month. We are going to get a choice next month. As a Federal employee, we have the same plan as anybody in the Department of Agriculture and Commerce. We are going to get a list of choice, and we choose. Why should not seniors get a right to choose?

Mr. HAYWORTH. If the gentleman will yield, I think that is absolutely the key point to this debate, and we have to ask ourselves, realizing that good people can disagree, and indeed we come to this Chamber to discuss issues of vital importance, such as Medicare preservation and Medicare improvement; we have to simply give people choice. You know, I listened with great interest, Mr. Speaker, as our friends preceded us in this special order, and I noted with interest a couple of remarks from my good friend from Washington State, and just to put this in some perspective, in my former profession, where I talked a great deal about athletics, I think my friend from Washington State offered the improper analogy. He was claiming that the new majority was trying to throw a Randy Johnson-like fast ball past the American people. I would take issue with that. Instead I would say that our friends, who are really guardians of the status quo and the old order, the new minority, is trying to throw the American people a hanging curve ball, because let us make no mistake about it, my good friend from Washington State who preceded us here in the well, those who studied the health care debate of a year and a half to 2 years ago realize that our friend from Washington State was the proponent of a health care plan, a national health care plan that can be safely said was even to the left of President Clinton's plan.

It was as if my friend from Washington State wanted to transmogrify the United States into the Dominion of Canada to try to bring that type of health care to this country, cradle to grave, soup to nuts, State-sponsored triage that was, in my humble opinion, irresponsible, with a massive centralized bureaucracy and putting health care decisions in the hands of government.

What we are trying to do is to change that, to say that the time for scaring the American people is over. It is time to provide options. We have options in every other walk of life. Why should we change at age 65 and only have one plan in a one-size-fits-all scenario? That is the wrong route.

Let us provide more choices even as we restrain the rate of growth. We still have growth in expenditures.

But I was also struck by one diagnosis that my friend from Washington State, as a psychiatrist, I think, was very appropriate in offering. In the early days of this Congress, as things changed, he talked about the fact that the guardians of the old order were, to quote him now, ''in a state of denial about the way things have changed here, and the new philosophies predominant on the Hill.'' I would simply add a footnote to that. Not only were members of the new minority in a state of denial, that denial has been followed by rage, and one of the lessons I have learned here, and I will be very candid with my friend from Florida, to my eternal regret, in the wake of the historic shift within this body, what we find so often now is that the debate has very little to do with policy and everything to do with power from the perspective of my friends in the new minority.

So jealous are they of the change in power that they will do anything, say anything, claim anything, to scare people about changes that need to take place, and so, again, I think that we ought to stretch out a hand and say good people can disagree, but let us suffer no illusions or delusions about what is going on here. We have a plan, a responsible plan to deal with the sobering realization that the trustees' report brought to the floor that Medicare, if we do nothing, goes bankrupt in the next 7 years.

Again, I hear our friends in the mass media, many of them almost acting as if in collusion with the new minority to claim it is to pay for some sort of tax cut. Nothing could be further from the truth. This is, as my friend from Florida knows, through the stewardship of the Committee on the Budget, the hard work of the gentleman from Ohio chairing that committee, we took care of making sure that all Americans could have more of their hard-earned money in their pocket, and this instead is in response to a bipartisan trustees' report that compels us to act now.

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In fact, as I see here, the gentleman has brought something to the floor from a publication not typically sympathetic to conservative points of view.

Mr. MILLER of Florida. I just do not understand what the point they are making from the other side of the aisle is. They agree we are saving Medicare. They say we are having choices. What is wrong with choices? They cannot disagree with the fact we are not changing the deductibles, we are not changing the coinsurance. They cannot disagree with that.

The premiums are going to continue going up, but at a slower rate than they have been going up in the past. So they cannot disagree with that. We are going after waste, fraud, and abuse. What is wrong with going after waste,

fraud, and abuse? I do not understand what their point is.

The Washington Post, not known as a Republican paper, says the congressional Republicans have confounded the skeptics. Our plan is credible, gutsy, and it addresses the genuine problem that is only going to get worse.

Let us see what the Washington Post says about the Democrats. My friend from Arizona, look what they are saying about the Democrats.

Mr. HAYWORTH. This is something. To use the words you have up here for us, let me recite it for the folks on what the Post has to say about the Democrats' MediScare campaign. ''Crummy stuff.'' ''Demagoguery, big time.'' ''Scare talk.'' ''Expostulation.'' Finally, quoting again, ''It is irresponsible.''

The fact is, as my good friend from Florida knows, we have yet to really see a definitive plan. And this is part of the frustration that I am sure the gentleman encounters in his district. As the gentleman's experience warrants in Florida, so too is my experience in Arizona. Many seniors living in the Sixth Congressional District of Arizona are saying to me, ''You know, you are right to try and fix this problem, and not wait on a commission or not take a Band-aid approach to say, 'Okay, there is a problem, but let us just try to solve it through the next election.''

Believe me, from the old days of politics, the easiest thing to do would be to stick our heads in the sand or try a little change here in the hopes that we could paper over it through the next election. But I know that is not what the people in Arizona or Florida or Connecticut sent us here to do. We are here to make the changes needed, responsible, reasonable changes, to improve this system; thus the name, Medicare Plus.

This is one other note we really have to reinforce, despite all the scare talk: If people like conventional Medicare, as they have it now, they are free to keep it. You mentioned the experience of your mother. My granddad is 91. He does not want a lot of things to complicate his lifestyle. He may very well want to stay on the program that has served him, and that, too, will be his choice.

Mr. MILLER of Florida. Let us define the problem. I am sure everybody listening here this evening understands what happened. The fund is going broke. It is going bankrupt. There is no dispute of that issue. The trustees, most of them are members of the Cabinet of President Clinton, but this is not a partisan issue. We are doing it together. The fund is projected to be exhausted in 2001. That is not politics; it is the facts, folks. We have to do something about saving Medicare. It is a simple fact it is going to be totally bankrupt in 7 years.

We have a trust fund. The only money going into this trust fund is payroll taxes. Under the Medicare part A, there is 2.9 percent payroll taxes that goes into a trust fund. The only money going out of that trust fund is to pay for Medicare part A. Next year, for the first time in the history of the Medicare Program, actually this year, which started October 1, more money will be going out than going in. For the first time in history we are going to spend more money out of that trust fund than money coming in in payroll taxes.

It is going broke. All the reserves, which are about $129 billion, are going to be completely gone in the year 2002, and then we have a disaster. And the real problem hits in the year 2010, because in 2010, that is the baby-boomer year, 65 years after the close of World War II, and when the baby-boomers start retiring. Everything blows up. So if we just put it off, the decision about Medicare, if we just put it off, what happens is it gets worse and worse every year.

We cannot put our head in the sand to try to solve this problem. We need to remember that the spending on Medicare has been going up at over 10 percent a year, and the private sector health care costs are going up much less. All we need to do is slow the rate of growth in spending.

This always bothers me, when they say we are cutting Medicare. Our plan does not cut Medicare. We increase spending every year on Medicare. Over the next 7 years we are going to spend $354 billion more than we spent on Medicare for the past 7 years. We are increasing spending by $354 billion more during the next 7 years than we did for the past 7 years.

It is going up every year. We keep saying only in Washington do you call an increase in spending a cut. I just do not understand how you keep increasing spending and saying you are cutting spending. The facts are the facts. We are increasing spending $354 billion over 7 years.

Mr. HAYWORTH. I just do not think we can state this enough. Now, I do not know by what mathematical gauge we are dealing here in Washington. I know George Orwell wrote of a ''Newspeak,'' a different type of language that said ignorance is strength, war is peace, and things of that nature. I cannot help but see the same type of pattern here with what goes on in terms of Washington numbers.

Now, I know the gentleman has been well respected in the world of business. Would the gentleman just review the numbers here again on this chart and explain again very slowly, so the American people can understand, and especially those who reside inside this Beltway, can understand what in essence is going to transpire.

Mr. MILLER of Florida. I am a former statistics professor, I have a Ph.D. and taught statistics for many years. It does not take a Ph.D. in statistics to understand this. These are simple numbers. The way you get these numbers, in 1995, we are spending $179 billion on Medicare, which is $4,816 per person for every man and woman on Medicare. The total amount of money we are spending right now is $4,816 per person on Medicare.

Now, in 7 years, we are going to spend $6,734 per person on Medicare. That is an increase per person, whether we talk about a total amount of dollars or on a per person basis.

Mr. HAYWORTH. An increase of almost $2,000, it appears.

Mr. MILLER of Florida. That is right, per person, almost $2,000 more. It is MediScare, fear tactics.

Mr. HAYWORTH. I notice, without having the privilege of taking one of your statistics courses when I was at North Carolina State, but just to put it in real terminology, I offered this example before and I think it has some validity here, in real live terms. When my daughter asked for an increase in her allowance, I gave her $5 a week until junior high. By the time she got to high school, we said, Honey, live a little. We doubled it to $10. I do not know if it was fiscally responsible or not. She did not grouse and complain and say, Daddy, you did not take it to $15. Therefore, you cut my allowance by $5. She had a genuine increase. Her allowance was doubled.

I think the point the gentleman is making is this is not rocket science, but is, as in the mid-to-late fifties, what Dwight Eisenhower used to call the study of government and description of politics, ''sophisticated nonsense.'' Lost among the sophisticated nonsense and fear tactics and rhetoric is this very simple message that is the foundation of what it is we are doing.

Again, I yield to my friend from Florida, because I do not think we can repeat this enough.

Mr. MILLER of Florida. One other chart that shows it is, let us look at it on a monthly basis over the next 7 years. This is what the Federal Government is spending per month for every person, beneficiary, on Medicare: In 1995, $401 per month; 1996, $423; $440; $460; $481; up to $561 per month per beneficiary on Medicare.

I just do not understand where you get a cut when you go from $401 a month to $561 a month. That is an increase in spending. In fact, when I explained it one time at a meeting back in my district in Sarasota, somebody got mad at me. Why are we increasing it so much? We can live within these numbers. They are live, and we can have a good program. I am proud of the program that we have on Medicare. It is an exciting program, giving more choices and options.

I am glad our colleague from Connecticut, Mr. SHAYS, is with us today.

Mr. SHAYS. Mr. Speaker, I just would like to weigh in on this. I was listening to both of you in my office and I felt compelled to join you, because this is something that we have been working on for years, particularly this last year.

We are going to spend $675 billion of additional new dollars in the next 7

years as opposed to the last 7 years. We spent about $926 billion between these last 7 years, and in the next 7 years we expect to spend about $1.6 trillion. That is an extraordinary amount of new dollars. Those new dollars are going to be used to help beneficiaries.

What amazes me is that when I listen to the plan, described by some of my constituents, that was described candidly by Members on the other side of the aisle, I thought, I do not like that Medicare plan.

They described to me a plan that created new copayments and increased existing copayments. That is a not. They described a plan that created new deductions and new deductibles and increased the deductibles that exist. That is a not. The hospital deductible, the doctor deductible is going to stay the same. They described premiums where they were going to have to pay more, and the fact is they are going to pay 31.5 percent, which is exactly what they pay now, and it will stay that way. As health care rises that premium cost will go up, as it has during the last 7 years.

I thought, none of that is true. As I talk to my constituents, they say it is a not. I have been told it was. It is not true. The bottom line is no copayment, no deductible, no increase until premiums. But they say, but I have been told I cannot have my doctors. I am going to be forced out to get private care. That is a not as well. It is not going to happen.

Beneficiaries can stay in the same program they are in now. If they have a doctor for their heart, kidneys, or stomach, or any other ill they have, they can keep those doctors. No change whatsoever.

I am excited about this plan, because it allows people to stay in the existing plan, but it then allows them to get into private care plans if they want. They can even have a medical savings account and buy a large deductible if they want to do that. They have so many options. They can stay in fee for service.

So I look at what we are trying to do, which is slow the growth of this program to about 6.3 percent. I would just come back to the original point: In the 7th year we are going to spend 54-percent more than we spend today. That is a gigantic increase. In the 7th year, beneficiaries, per beneficiary, are going to get 40-percent more per beneficiary.

I look at the plan and say this is a job well done. I would defend this program anywhere. I would debate anyone on this issue. It simply is a plan we can be very proud of. I hope ultimately the American people are focused in on what this plan is and not a plan described by people on the other side of the aisle who simply want to prevent this from happening.

Mr. HAYWORTH. Mr. Speaker, I think you make such an outstanding point, that we have to remember that we are offering again, as our good friend from Florida pointed out at the outset of this time together, we are offering choices. And the ultimate choice is if people like what they have, they can keep it.

Again, I am struck by the difference. It is interesting to see some Members of the fourth estate try to cover this debate and try to draw an analogy with the failed soup to nuts, cradle to grave, socialized plans that were offered 2 years ago and say that somehow there is a synergy between the two things.

Nothing could be further from the truth. Going back to our analogy of the hanging curve ball, how interesting it is that guardians of the old order and proponents of socialized medicine are now coming to this floor saying that we denied, or that we would deny people their choice of their own physician.

Nothing could be further from the truth. There is no synergy between these two episodes in history. We are offering something profoundly different, predicated on what is, I believe, the essence of being an American, the chance to take a look economically and personally at what is best for our future destiny and having an option to determine what is best.

It is so interesting to hear the descriptions, as if latitude in personal decisions is something to be feared or as if there is some sort of unseen compulsory action that will take place that will force people into certain programs.

Nothing could be further from the truth. We are enlarging choice for the American people and renewing freedom that heretofore has been denied for the past 30 years, despite the virtues of this program, when people magically hit the age of 65.

Mr. SHAYS. Mr. Speaker, one of the plans we are allowing, we are allowing doctors and hospitals to have their own program. In other words, they can now compete directly with the insurance industry; they can compete with HMO's, health maintenance organizations. They can participate in this process. I believe that they will be able to provide patients extraordinary care at significant reductions in price.

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One of the things that happens is in this process of choice, they can stay in their fee-for-service. The only way they have to leave is they have to choose to leave. And the only way they will choose to leave is if they can get better health care in one of the private plans.

So, for instance, if a private plan wants to say that their premium will be less, they will get a rebate or, in fact, their deductible, which presently is on hospitals and doctors, would be reduced, they can get that. Some plans might entice individuals to participate because they will get drug care for the first time, or eyeglass care or dental care, which they might not get now. The only way that happens is if they can convince individuals they should leave their plan.

Now, if they leave their plan, under our proposal, we are allowing Medicare patients every month to go back into their old system. There is a 2-year window where they can simply go back the next month. And then, in the third year, it would be every year. So we are saying if an individual really wants to test it, and they are not sure they will like it, they can go right back to what they have.

I have tremendous confidence a lot will choose to do the private care and they will stay there because they will find they will be better.

Mr. MILLER of Florida. I think those are very important points to remember. Two important points the gentleman has made. Traditional Medicare will be there. My 86-year-old mother is not going to change, and that is fine. I think she should have the right to stay in the system the way she is. She is not going to want to change. So everybody has the right to stay in the system.

The other important point is, during the first couple years of this, with 30 days notice, an individual can change back to the system. They can change every month if they want. What is wrong with that? Why would someone object to having the chance to choose, and if they do not like it, change again? It is their right to choose. Just like as a Federal employee we get to choose once a year. That makes sense. What is wrong with that? I don't understand what the scare tactics.

Mr. HAYWORTH. If the gentleman would continue to yield, I know we listened to our colleague from Vermont [Mr. SANDERS] bemoaning prescription costs. Again, the gentleman from Connecticut [Mr. SHAYS] has pointed out what may very well be one of the virtues of these many different plans, that there may be copayments and reduced fees for the very prescription drugs that my friend from Vermont was so concerned about.

This is really the essence of the debate we are having here. Again, good people can disagree. There are some who legitimately believe that it is the domain and the responsibility of the Federal Government to act not only as the charity of first recourse, but to be the principal architect and the principal provider of about every service here in the late 20th century. I think, fundamentally, the American people reject that notion, but the American people look for a plan that empowers the populace, that empowers the citizenry, and that can give them the very choice they need to make responsible decisions. Again, those decision governed by their particular situations and their particular lifestyles. That is what is so important.

So the very thing that our friend seemed to fear, may, in the final analysis, be a phantom.

Mr. SHAYS. If the gentleman would yield, we basically have a plan that has no increase in the deductible, no increase in copayment, keeps the same premium cost, allows individuals to keep the present system they have, allows them to move into private care, if

they do not like the private care, they can come right back in.

Someone said, well, why not take the premium, which is 31.5 percent and have it go down? What they are saying is, on Medicare part B, which is what the premium pays for, all the health care services, we are saying the taxpayer is going to continue to pay 68.5 percent. If we allow the premium to go down, we are then saying the taxpayers are going to have to pay 70 percent and 80 percent and so on.

So we are saying taxpayers will stay at 68.5 percent for Medicare part B, and those who receive the care are going to stay at 31.5 percent. To me, that is a very honest and straightforward way. The taxpayers will have to pay more as health care costs go up, and the premium will also go up slightly as well, but we are keeping that bond and that protection.

While we are not always mentioning this, it is something that I think should be put on the table. We are trying very hard to make sure that there is not a transfer of wealth from families to senior citizens. We have to be straight with everyone here; that the Federal Government cannot continue to pick up more of the percentage, because, otherwise, we will make families poorer and poorer. And it is not easy for a family today with two children, that makes $40,000, that now does not have the same deduction per child that my parents had. My parents had, in today's dollars, the equivalent, $8,000, they could take for each child, and a family today has $2500. My parents paid about 20 percent of their income in Federal, State and local taxes. A family today pays 30 to 40 percent.

We have to, when we talk about what we are doing for our elderly so we can protect Medicare, we also have to focus in on what we are trying to do for families.

Mr. HAYWORTH. If the gentleman would yield, I think he makes a very, very valid point. And, quite candidly, there have been those seniors that have come to me, and perhaps other Members in your respective districts have found this to be true as well, and they say, now, wait a minute, what about this whole notion of tax cuts? So many of those seniors I talk to I ask, and many of them were starting a family in 1948, maybe had a couple of kids. Back from the war, starting a career. And for an average family of four in 1948, 3 percent of that family's income went to the Federal Government in terms of taxation. Now, compare and contrast that with last year, when a typical family of four surrendered almost one quarter, 24 percent, of its income to the Federal Government.

As the gentleman from Connecticut [Mr. SHAYS] points out, with State and local taxes, with the hidden cost, the hidden taxes, if you will, of regulation, more and more people are surrendering 40, almost 50 percent of their income to the Federal Government.

So, again, what this new majority is trying to do, what we are tying to do in the Congress of the United States is empower people, not only the seniors but the families, to have more of their hard earned money. The people of the 6th district of Arizona last November sent a very simple message to Washington through my election, and that is this. We work hard for the money we earn. Let us hang on to more of it and send less of it to Washington. That is not born of a selfish impulse. Simply people realize that the place for charity does not come from the Federal Government being the charity of first resort.

And while there have been many innovative programs designed to empower people, we cannot empower people on one hand and yet enslave others with the same type of equation. There has to be opportunity across the board.

And I thank the gentleman from Connecticut for bringing up that very real challenge, whether it is income tax or payroll tax for part B Medicare in that trust fund. We have to understand that the work force today is called on more and more to pay taxes and they need to hang on to their money, and we have to find a way to get that done.

And that is why this plan, I believe, offers the best alternative yet devised to empower people and to work this problem through.

Mr. SHAYS. I wonder if the gentleman would yield again. I want to point out that we are a family in this place, in terms of our desire to take on some very tough issues. I have been here 8 years, and this is the first time we have had an honest dialog with our constituents about the need to deal with entitlements and control their growth. Slow the growth. Allow them to grow faster than any other part of the Government, but to slow the growth and to make some very necessary spending reductions in domestic spending.

We have been very honest to say that we have to get our financial house in order and balance the budget. That is our first task. Our second task is to save our trust funds, particularly Medicare, which the gentleman from Florida [Mr. MILLER] has focused so eloquently on. And our third task is to change the social corporate welfare state into an opportunity society.

We are going to do our best to save this American civilization and have a society where people can prosper.

Mr. MILLER of Florida. I am excited about the plan we will vote on on Thursday. It really is a great plan, and I am proud to be able to be part of the process of being able to introduce it on Thursday.

When we talk about the process, the gentleman mentioned talking to your constituents, and our friend from Arizona also. The thing that made our plan I think a successful plan is that we have been talking to the people that make the difference, that make the decisions that it impacts.

So often they want to have these hearings and we have all the policywonks, and maybe some from your State and my State, that come up here and say here is the theory. This is the way it should happen. I think that was the mistake in the plans last year. We have had over a thousand town hall meetings throughout the country listening to people. I am having another one this Saturday in Sarasota. I had one in a mobile home park in Ellington, FL, a week ago. I have them all the time, listening to the people and getting their input.

In addition, we have listened to the organizations that are on the front line. We have listened to the AARP, we have listened to the hospital groups and the physician groups. We have listened to the different groups that are on the front line and delivering care, and they believe what we are doing is the right direction.

There may be some differences. They may not wholeheartedly support this. They may not like something in it. The trial lawyers may not like us, of course. But the thing is we have listened to the people. That is the most important thing, the ones on the front line, rather than just the policywonks. The message basically is save Medicare and no Band-Aids. Let us fix it now and let us address the problem.

Mr. SHAYS. I wonder if the gentleman would continue to yield, so that I can point out and use real numbers. One of the points I want to make, and the gentleman from Florida, I think, represents an extraordinary number of senior citizens and your input, as in my work, as we have worked together on the Committee on the Budget on Medicare and Medicaid, has helped shape this plan, and that plan has been shaped by what we have been hearing.

My constituents have said, I have to keep my own doctor. Done. I have had other constituents say I want some choice. Done. I have had other constituents say I would like the opportunity for plans to give me eyeglass care or dental care. Done. Or prescription drug care. Done. I have had other constituents who have said I want the opportunity to have a medical savings account and to buy only catastrophic care. Done.

I mean we have been listening. That is not the way our plan started out. It has been shaped by the constituents we represent.

Now, I have had a number of constituents, I have had, candidly, I went to a funeral last night, where the member who passed away was a member of the Republican town committee. And I had one of my best supporters walk down the stairs and say, ''Don't you dare. Don't you dare make any change in my Medicare plan.'' I said, ''Tell me what are you concerned about.'' She said, ''I am concerned you are cutting my medicare plan.'' I said, ''Well. We are allowing it to grow at 6.3 percent.'' ''No, I heard you were cutting. I heard this from the AARP.'' I said, ''We are

slowing the growth.'' Then she said, ''Well, AARP told me I cannot have my own doctors.'' I said, ''Well, that is not accurate.'' I said, ''Hold it.'' We just went through the entire plan. And she said, ''If that is the plan, I support it.''

My conviction is that there are a lot of people right now who are being told a lot of things. I have had some of my colleagues go to nursing homes saying nursing homes will be closed next year. I have had some of my colleagues having press conferences with doctors saying they will not be able to have their doctor anymore. None of that is true.

Now, what is my conviction in voting for this plan? We have worked on it for an extraordinarily long period of time. We have had the input of so many different people who have told us what they want in the plan, and that is what we are doing. I am absolutely convinced that next year, when people see this plan unfold, and, candidly, that is when I have to face the electorate. I would not want to be so stupid as to do a plan that is unfolded and then does not work. That does not make sense for our country and it certainly does not make sense for anyone that has to go back to the electorate.

I am proud to defend and promote this bill when we debate it on Thursday, and I will be proud to defend it and promote it during the course of all next year. And I predict that people next year will say ''What a great plan, and thank you for making sure that I could keep my existing health care, and if I want, I can change it and get other kinds of health care that meet more of my personal needs.''

Mr. MILLER of Florida. I agree with the gentleman completely. I think 5 years from today people will sit back and look at what we had in Medicare, the one-size-fits-all model, and people will say, ''Why did we wait so long before we made the changes in Medicare; before we gave choices?''

We were criticized that, oh, we had one day of hearing. Wrong. We had hearing after hearing. We worked together in the Committee on the Budget. We had representatives from industry in and actuaries and different groups in at different committees. At least 38 hearings this year on Medicare. So we have had the official hearings, lots and lots of them. Plus, we have built on all the hearings we have had for years.

I was lucky to serve on the health care task force that the gentleman from Florida [Mr. MICA] had for the past couple of years and, really, we had a lot of hearings and worked very hard on the plan there. So we listened. And when people came with ideas, we would go and say, ''Can we do this?''

I will tell my colleagues some ideas that senior groups advocated. Any plan that is offered under our Medicare choice program has to offer benefits at least as good as current Medicare. So any plan they choose, they are going to have at least the same benefits or better.

Mr. SHAYS. Let me get this straight. So if a private plan, when the private plan steps forward, they have to tell and make sure that their health care plan covers everything that Medicare presently does plus.

I do not know if the gentleman from Florida was the one who had thought of the name of Medicare plus, but it is such an apt description of what our health care plan does. It allows them to have their existing health care plan plus.

Mr. MILLER of Florida. Right. Because the current Medicare system is going to continue. For those that want to stay with it, fine. But why not give those choices? As long as any choice they choose has benefits as good as the current Medicare, what is wrong with that?

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We are hearing people that have these other options for people that are low income. There are some choices out there that are going to be less money. It is going to cost them less and they get more benefits, if we just allow the marketplace to help bring the costs under control.

So, I am excited about the options, because we are going to give people the choice and they are going to say, ''Great, why did we insist that it could not be changed?'' It is exciting, what we are going to have, and I look forward to that.

Let me talk about the some of the choices we have. We always start off with the fact that the current Medicare stays. The plan, basically, is that every year beneficiaries are going to get some forms and they get to choose. If they want to change plans, fine. If they do nothing, they stay in current Medicare. If they want to change, they get assigned a form to change. But if they want to stay in the current plan, they stay in it. It is automatic. Nothing to do but just stay in the plan and it continues just the way it is. There are no changes.

But then we have these choices: Medical savings accounts, or the HMO-like organizations, or the provider service networks. I think these provider service networks are going to be exciting in local communities. When you think about it, most health care is local. Ninety-eight percent of the health care we receive is our local doctors, our local hospital, our local home health care agency.

Why not encourage the local doctors and the hospitals to go together and form their own program? As long as they meet the financial standards and they can buy reinsurance to provide those financial guarantees to make it sound, why not encourage those local hospitals and doctors to go together to form their group? They know their patients and communities best.

What is good in Florida may not be necessarily good in Connecticut or Spokane or Arizona. I have hospitals with 80 percent Medicare populations because of my high senior population. They are going to be most interested in this.

I am very concerned about Medicare. We cannot let that program go bad. We cannot let it go bankrupt. It is job in our community and for the senior citizens in our community. My own mother. We have choices that are going to bring it under control.

We have had over a thousand town hall meetings and coming up with some great ideas. Our leadership and our committees have listened and put the ideas that our Members found in town hall meetings into the plan. One of the biggest things they talk about is waste, fraud, and abuse. We all agree that we need to get tough on waste, fraud, and abuse. This is where a lot of the money is.

We believe that the marketplace is one area that is going to help drive that out. When we have competition for the business and we have to satisfy those patients, if they do not like it, they leave and go some place else.

I have a restaurant. If customers do not like my restaurant, they can go down the street to the other restaurants. We have to keep people satisfied, and if the doctor is not doing a good job, the patients will go down the street. That is going to force it out.

They have to efficiently provide the service at the same time. We are going to give seniors an option to help us root out the waste, fraud, and abuse. It is hard for the bureaucracy in Washington to discover all the waste in the system. It is hard to discover it out here, but patients come up to me all the time and tell me about the problems.

One case was on network news. The lady was talking about being billed for an autopsy when she was in the hospital. That is a little bit extreme, but if they can locate the problems, let us give incentives to seniors to go out and find that waste, fraud, and abuse. So much of this is related to defensive medicine where the lawyers have driven up the cost. If we can do that, we can have benefits that are going to address that issue.

I am glad that my colleague, the gentleman from Florida [Mr. MICA] is here, because he has a large number of seniors in his district just north of Orlando.

Mr. MICA. Mr. Speaker, I thank the gentleman for yielding. I cannot think of anyone in the Congress who probably represents more seniors than the gentleman from Florida [Mr. MILLER], and who has been more active in trying to bring some fiscal responsibility to this Nation and also to the Congress.

I am also pleased to join the gentleman from Connecticut [Mr. SHAYS]. I know many of the Members, particularly on this side of the aisle, and there is no one who has greater sense of compassion for the people of this country, their needs, and who cares more about human beings in our Nation. I have seen him work in this fashion and toward a compassionate solution to

many of the problems that confront us. I am extremely pleased to join both of my colleagues this evening to talk about Medicare reform.

I have really remained somewhat silent. I have held my town hall meetings and looked at what the Republican proposal was. Tonight, I am here to strongly endorse the House Medicare reform proposals.

I have looked at them. I have talked with our seniors. The nice thing about senior citizens is they were not born yesterday and they have seen a lot of water over the dam and heard a lot of rhetoric and they have been able to sort through some of the smoke and charges and rhetoric from the other side of the aisle.

It is unfortunate that some of these people have not come up with what is a new idea, or some new solutions, in more than three decades to some of the mounting problems of this country. I am here tonight to say that, in fact, I think the greatest threat to our senior citizens is the national deficit and we must do something about it.

I brought a couple of charts that I blew up. They are not very colorful, but one of them I wanted to show to our seniors and other Members tonight was the fact that our Federal budget in 1995 now is composed of $153 billion in entitlements. That is some of the welfare programs; $333 billion in Social Security, and that we hope will stay off budget and is not affected by anything that is proposed by our side of the aisle; Medicaid is another $90 billion; and you see Medicare $176 billion. Then you add in interest on the national debt and we are looking at somewhere around two-thirds to three-quarters of our entire expenditure for the Nation.

What this says is that we must do something to bring some of these costs into check. The two biggest Government programs are the health care programs, Medicare and Medicaid. And even a simple mathematics computation will tell us, and the President's own trustees, and I brought a copy of that, that basically, that the trust fund is projected to become exhausted.

What I said about simple math is we have been spending somewhere between 11 percent, 10.5 percent, and 13 percent per year. And simple math will tell us that in about 7½ years, if we continue at that rate, those huge expenditures will bankrupt the system and this chart again goes completely awry and we cannot bring the finances of this country into order.

Now, what is even of concern not only to seniors, but what should be of concern to working men and women, is the country's population and its worker base actually starts to decrease. The ratio of active workers to Medicare beneficiaries in 1995, as you can see, is way up here on this chart: 3.3. And if you look at the year 2035, it is down to 20.

So, what is going to happen is people who are now concerned about what is being taken out for Social Security and other taxes and Medicare, there will be a smaller pool to draw from. They will be able to take home very little and we will be taxing them to an unheard of degree. We will not be able to support the system.

So, we did not create the mess. We may have been here while the mess was created, but, in fact, the other side has had control of both the House and the other body here. We see the same thing, whether it is the District of Columbia, it is Amtrak, whether it is Medicaid, whether it is the pension funds that I oversee for the Federal Government on the House side as chair of the House Civil Service Subcommittee. All of these programs are basically bankrupt. We have robbed from the cookie jars and now we have to face reality.

But I think that the plan that we have come up with, you have heard my colleagues, Mr. MILLER and Mr. SHAYS, outline some of the things that we have done. We addressed the real problems here.

Everyone knows, every senior who has attended any town hall meeting that I have held has come forward and said, Mr. MICA, look at the waste, fraud, and abuse. Look how much I was charged for this 15 minute service. And they hold up a bill. Look how much this item cost, this overbilling.

The Miami Herald in Florida did an article on Medicaid fraud and they estimated a $1 billion fraud and abuse of the system in just the State of Florida.

Mr. SHAYS. The gentleman said 1 billion?

Mr. MICA. Yes, $1 billion in waste, fraud, and abuse. And that is the cornerstone of the Republican plan, is to tackle some of that. Every senior has seen it when they have sat in an office and seen how the system is abused. When they have seen the billing, they see the net results.

We had one individual come to a town hall meeting and talk about what he was forced to pay for a wheelchair. He could have purchased probably four or five wheelchairs for what the system required him, or the system and the taxpayers to pay for under this ridiculous system. So waste, fraud, and abuse are an important cornerstone.

Medicaid is the same thing and we will not get into that tonight. but I sit on the subcommittee and we oversaw Medicaid with the gentleman from New York [Mr. TOWNS], and Medicaid in Florida is somewhere in the neighborhood of $1 billion in waste just by estimates of the General Accounting Office report that our subcommittee received last year. So, the cornerstone is doing something about waste, fraud, and abuse.

Then, the second point is tort reform, and we know we have to face tort reform. We sent to the other body litigation and legal and tort reform that is so necessary, whether it involves medical expenses. And we see that again. Someone said a doctor charged so much for an office visit. And I checked with the doctor to see what his liability was. His premium is $50,000 a year. That is a thousand dollars a week. If you do 100 visits, that is tacked on at the front end of every visit.

We have to do something to bring some of the need for reform into place here as far as tort and liability reform. A second major point.

And then again my colleagues have described the opportunity for choices. No one is forced out of Medicare. No one is forced into any plans under what we are proposing. Beneficiaries are given choices. What is wrong with choices? And choices that we offer will create competition. We think we will drive prices down. We are not positive it will work, but we think from the models that we have seen, from pure logic, that competition and also having various plans such as we have in the Federal Health Benefits Program that I oversee, also as chair as the House Civil Service Subcommittee, people will have the opportunity to choose from a variety of plans which will begin to be self-policing.

And we have seen that. They bring down costs. They offer more options for folks. Things like medical savings accounts, which makes so much sense. What is wrong with providing an alternative to bankruptcy?

It is all done, too, on the House side we say no change in copayments. No change in deductible and the premiums remain the same. Seniors can stay in Medicare. We can reform Medicare and also offer choices, and I think that makes sense. The most important thing is it helps bring the finances of the country and the system into some balance and we will not bankrupt the system or the country.

Mr. SHAYS. When the gentleman said not positive it will work, I am absolutely as positive as I can be that this system will work extraordinarily well. The issue is will the savings be 270? 260? 280? How many people will choose private care? Will it be 24 percent that the Congressional Budget Office says? My judgment, based on all the people that we have interviewed, says that well more than 50 percent by the seventh year will have chosen private care. They are going to choose it because they get better opportunities.

The certainty is no one can predict exactly what it will be in the seventh year. Is it 45 percent who are in private care? 60 percent? 70 percent? That is the uncertainty. To what extent will that happen? But the one thing we are certain of, we are certain that we will provide $4,800, as we do not, per beneficiary. We are certain that we will provide $6,700 in the seventh year. That is a 40 percent increase per beneficiary.

There is over $600 billion into the plan. Doctors will get more; hospitals will get more; all the people who provide quality service will get more, not less.

☐ 2015

There is not anything like an increase in the number of hospitals and

doctors of 40 percent. So those who are in the system now that are being told that somehow they are going to have to make extraordinary sacrifices, it is just not accurate.

Mr. MICA. Well, again, Mr. Speaker, nothing is certain. We are trying to do our best. We all have relatives. I have aunts who are on Medicare and trying to make if from week to week and month to month. We are concerned about these people. But our number one concern should be that we do not bankrupt the country. And simple math will show you that this whole structure we have created, this huge government program is going to collapse. Even the President's commission says that.

So we are willing to work with the other side. We are willing to work with the administration. We are willing to work with people who have ideas. We have held hundreds of hearings on this and Members have held literally thousands of town hall meetings trying to bring together the best ideas into a plan that makes sense.

The last thing we would want to do is hurt any senior citizen, someone in need or someone who needs that care. We think we can do a better job, and it is not necessarily throwing more money at the problem. That seems to be the only solution around here.

Do we do a better job, as proposed by some folks on the other side of the aisle or the administration, just by ignoring the problem or letting the waste continue? Well, we will let the waste go to 89 billion or let the waste go to 100 billion. This does not make sense. We need to make the system work and it should operate and function in a responsive, accountable fashion and give the people the choices that others have. Why confine them to one failed choice?

Mr. MILLER of Florida. You are chairman of the committee that is involved in Federal employee health insurance. We looked at that. That is basically what we are going to offer senior citizens, a separate system that gives a choice just like all Federal employees have a choice.

The Medicare program is a very complex system. If you are under Medicare you have to have three different insurance plans. You have a Medicare part A with one insurance company handling that. You have Medicare part B, which costs $46.10 that another insurance company handles, and then you have a Medigap policy. That is a complicated system. That is part of the inefficiencies of Medicare. And as a Federal employee, we only have one insurance plan. Anybody in the private sector has one insurance plan. That simplifies it. It is going to be so much simpler. The benefits are going to be better, and we are going to slow the rate of growth. I do not see where the argument is, why anyone could disagree. We have more money every year.

Mr. SHAYS. I would love to just emphasize that point. I had more constituents who said, I want the same kind of choices you have, Mr. Congressman, hopefully they call me CHRIS, but the bottom line is, they are saying as a Federal employee I get to choose a wide range of programs. I have to pay 28 percent of health care costs. But I can choose any kind of program. I can choose one that is more expensive, less expensive and so on. I just want to emphasize, the gentleman from Florida is right on target. We are doing what our constituents have asked: Give us the same kind of choices you have.

Mr. MILLER of Florida. I am excited about the plan. I think we have been debating health care for almost 3 years. Now we are going to be able to do it. We are going to make the changes. We are going to give a better system to the seniors of our country. We are going to preserve a program that is so essential that we have to have it, and it is going to be there and it is going to be a much better plan. I do not understand what all this scare rhetoric is. It is politics. People do not want politics on this issue. It is too important for politics. I am getting tired of the scare tactics that keep coming in from the other side.

Mr. HAYWORTH. I guess it is just a situation where Halloween came a little bit early and lasted for the better part of 3 months. The chances now for us to expand choices, to offer real reform rather than a Band-Aid approach for the American people and preserve this program so that we can take the steps necessary in later years, indeed to preserve it for future generations, it is summed up in the name Medicare Plus. And as both my colleagues from Florida, Mr. Speaker, have indicated, it offers choice. And as my good friend from Connecticut so articulately phrased it, what is wrong with having that type of choice. We will leave it to the American people who duly elected us to debate this issue and make the necessary changes to preserve, protect, and improve Medicare.

Mr. SHAYS. I would just like to say, if I could, I compliment the President on one issue. He said to the American people, we need to deal with health care. It was a big wake-up call for a lot of Members of Congress. And what the President did is set in motion a number of us, if not all of us, giving this our number one priority and studying this issue tremendously. And so for that, it has been extraordinarily helpful because this is not something we just started working on.

You started and others and my colleagues started well before the President asked, but the general bottom line is that we have been working on this health care issue for over 3 years now and we think we have come to a plan that the American people really will find is what they want.

Mr. MICA. In closing, I just want to say again that I do not think there is any greater threat to senior citizens or all Americans, if this Congress does not act responsibly on the fiscal problems. And they are not just Medicare, it is a big item, but it is also providing jobs and opportunity for this and future generations. And some of that does involve changing our tax policy. So we are going to have to do all of this. I think if we work together we can do a better job and we do not have to scare anyone in the process. But I think all of us working together we can improve what we have.

Mr. MILLER of Florida. Mr. Speaker, just in closing, for the seniors of this country, we have a good program. You are going to be excited by this program when it comes out next year. It is going to save a system that is essential to keep up.

Do not get scared by the rhetoric out there. It is going to be a good program. You are going to be very pleased with it. It is going to continue to exist and that is what we are here for. We are going to preserve and protect Medicare.

STATE OF EMERGENCY

The SPEAKER pro tempore (Mr. GUTKNECHT). Under a previous order of the House, the gentleman from New York [Mr. OWENS] is recognized for 60 minutes.

Mr. OWENS. Mr. Speaker, the state of emergency continues. You have just heard some of the brightest and most decent human beings in the Congress make a long statement about Medicare and health care funding, and neither one of them admitted that Medicaid will cease to be an entitlement under their bill. Millions of Americans who are now covered right now by Medicaid will no longer be covered as a result of the legislation that they want to pass.

They have not admitted that we are the only industrialized nation, we are the only industrialized nation other than South Africa that does not have universal health care coverage of some kind, are not moving in that direction. We were moving in that direction with Medicaid coverage for the poor, but they are going to take away the Medicaid entitlement. They say that we are going to be happy when we see the package. Americans will be happy when they see that less people are covered as a result of this legislation than were covered before. We are going backward and we should be happy.

There is a state of emergency that ought to be recognized here. Nearly half a million dedicated troops were here in Washington yesterday. Unfortunately, they had no commanders to tell them about the state of emergency. Unfortunately, no one told them to concentrate on the place where the real battles are being fought. They do not understand were the real battles are taking place. They do not understand that the state of emergency directly impacts on their lives.

They came, they are engaged, and I hope they will remain so. I want to discuss tonight how they must be energized and informed and directed to become a part of defending themselves

against the big guns that are aimed at them and their way of life.

Nearly half a million dedicated troops were in Washington yesterday. Nearly half a million young black males marched yesterday. But they were not told the nature of the war they are in and the danger they face, and they were not told how best to engage the enemy.

I want to talk about how they must engage the enemy.

First I want to just describe what happened yesterday. I want to use the language of some of the editorials and columnists who have commented on it. In the Daily News of New York City, the Daily News language I think was very sensitive to what happened. I quote from the Daily News editorial of today, October 17:

The pain of generations of hope denied brought a sea of seekers to Washington. They came seeking solutions to the problems that divide them from the rest of the nation and from themselves. From the cold of early morning to the setting of the sun over the Nation's Capitol, they stood patiently, admirably, listening, waiting for words to heal them, to inspire them. Most waited in vain. But the power of their presence was so strong that it captured the attention of a nation. The power of their presence was so strong that it captured the attention of the nation.

I think it is important to note that these dedicated young men who came, according to one poll that has been taken, came for many different reasons. Unfortunately, too few of them came to Washington, the capital of power, and understood that not only could they capture the attention of the Nation but they could do more.

They could have focused in on some of the emergencies that exist right here in this legislative hall. We are going to have a vote this Thursday on Medicare, Medicaid. Nobody talks about Medicaid very much, but Medicaid is part of the package, too. There is going to be a huge cut in Medicare. That is horrible. We want to stop that cut. I do not think we have the votes. It is going to pass the House with that huge $270 billion cut over a 7-year period. More than $180 billion will be cut from Medicaid. And Medicaid will no longer be an entitlement. Right now it is an entitlement.

In case people do not know what entitlement is, entitlement, in summary, is the Federal Government saying that you as a citizen of the United States have a right to this particular benefit if you qualify for it. It is a means-tested entitlement. It is not like the farm subsidies or cash subsidies in the farm program. No matter how rich you are, you are entitled to your cash subsidy for the growth of tobacco or peanuts or whatever.

Medicaid is a means-tested entitlement. You have to profess you are poor. You have to prove you have great need before you can qualify for Medicaid. And Medicaid is as close as we have gotten in this country to coverage of the poorest people with some kind of health care plan.

We are like South Africa in that we do not have any effort going forward to move toward universal coverage. So, even that which exists already under Medicaid will be taken away. And the only hope that is being held out is in the Senate where the great debate in the Senate is, they will leave the entitlement in place for pregnant women and children. They will leave the entitlement in place for pregnant women and children. They can get Medicaid. But the young black males and all the other poor males of America, you will not be entitled to Medicaid, no matter how you qualify.

If you have an accident on your job, the likelihood is that you will be in a situation where you do not have health care coverage because so many of the kinds of jobs that these young black males will have or young males entering the work force are not jobs where you have a health plan. There is no health plan. So young males are in jeopardy in terms of not only accidents on the job, which there might be some relief in terms of workmen's compensation, but they are in jeopardy in terms of other kinds of illnesses.

They are certainly in jeopardy in terms of the violence that takes place and I have seen by visiting some hospitals where they have convalescing people who are receiving therapy, large numbers of young men who are the victims of gun shots, gun play, and other kinds of violence that have partially disabled them, not only black men but white men also. Violence often causes young men to need a great deal of health care, very expensive health care, also, health care for people with great disabilities.

So they have the guns aimed at them. Speaker GINGRICH has said that politics is war without blood. So I do not hesitate to use the analogy of guns. Politics is war without blood. While we dillydally these few days, it is very slow around here, not much happened on the floor today. We had a few votes, we had a few suspensions discussed, but the guns are being maneuvered into position. Those guns will be aimed at the programs that have been put in place over the last 50 years, programs which are compassionate and programs which seek to help poor people, people who qualify because they are poor and they need help.

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We have all kinds of programs in America which help people. We have programs that help people that have been victimized by earthquakes, and they do not have to have means tests, does not matter who it is. People have been victimized by floods. There is no means test necessary to get government assistance. There are those victimized by drought or by hurricanes. There are ways to get help without means tests. So we have a humane society in many ways that extends help, but we are saying for people who are in dire need of help because their health is a problem, ''We are going to cut it off. We are not going to have the Federal Government stand behind that. We are going to dump it off on the States.'' And the States have already made it quite clear that there is a minimum amount that they are going to offer in terms of additional help beyond what the Federal Government provides at present.

The big guns are aimed at the young men who were here yesterday. The earned income tax credit benefits poor families. It is a way to benefit working families. It is a way to reward people for working. We say we want people to go to work, and the earned income tax is one idea that brings to life the notion that people should be rewarded for work, but that is going to be cut, too. The gun is aimed at the earned income tax credit.

The guns are aimed at job training. We understand there are a lot of people being thrown out of work. There is a change in the industrial situation, and companies are changing in terms of technology. Downsizing, streamlining is taking place. I have talked about this before, and the only answer to it is in this transition period maximize the amount of education and job training so that people can recycle themselves, be helped to recycle themselves, but job training has been cut, too. Job training has been cut by $5 billion by this Republican-controlled Congress. Job training programs cut, education programs have been cut, by $4 billion.

The guns are aimed at the young persons who were here yesterday, and they did not hear anybody really focus on how important it was for them to understand and to rise up in very concrete, nonviolent, political ways to defend themselves.

Summer youth employment; many of the youngest youngsters there qualify for a summer youth employment program which has existed since the Great Society programs were created by Lyndon Johnson. Every summer minimum-wage jobs are available for 25 to 30 hours, and youngsters who are given those jobs and given some kind of training and prepare for the world of work as well as help to earn, allowed to earn, some money to go back to school, and I know from direct experience many of them end up contributing to their very poor families from the meager amounts of money they make in the summer youth employment program. That is zeroed out. The summer youth employment program, it is not just for men. It is for women, too, for females, too. That is zeroed out. It will exist no more as a result of legislation passed by this Republican-controlled House of Representatives.

The Senate, I think, have pretty much followed suit. I do not know of any effort to revitalize it. Title I, direct education program, Federal money flowing into the schools which have the younger sisters and brothers of the males who came here yesterday. Their nephews and nieces and their children

are in those schools. Title I is the only Federal program that helps elementary and secondary schools all across the Nation, and we have cut that by $1.1 billion, which is one-seventh of the total amount.

Those young men and their families are targeted by the guns that are aimed at them, and they did not realize it. We must get to them and make them understand that there is a state of emergency and they must be involved in the fight to reverse this state of emergency. Their survival is at stake.

The crime prevention programs that were passed in the last Congress are on the chopping block. There is no more crime prevention of any significance in the bills that were passed by the Republican-controlled Congress. There are more prisons in greater amounts, and there are harsh regulations which force prisons to focus primarily on punishment and not on rehabilitation, but the young men who were here yesterday were not told about these changes.

Drug treatment is out of the window. Nothing of significance is going to happen with respect to drug treatment. The funding is no longer there.

One in three black males now are somewhere in the criminal justice system, either in prison, on parole, or probation, or under some kind of court supervision, one in three black males in America. A few years ago it was one in four. When these statistics came out, everybody was shocked. One in four black males in America are in the criminal justice system somewhere. Now it is one in three. In a few years will it be one in two? There is nothing to stop us from moving in that direction. But not much discussion of that took place yesterday either. We have to deal with the one in three right here.

There are bills on the floor in the next 2 weeks dealing with the prison system directly. The Sentencing Commission has recommended that we stop the discrepancy between the sentencing for people that have crack cocaine and those who have powdered cocaine because large numbers of blacks, females, and males, are being imprisoned for the possession of crack cocaine when more expensive and larger amounts of powdered cocaine, which are generally the choice of richer people, more affluent people, middle-class people, more white people; those persons are not sentenced in the same harsh way that those who have crack cocaine are. The Sentencing Commission has recommended a change, but the Republican-controlled majority does not want to allow that change to take place. The Sentencing Commission sees it as being the only just way to go, but that kind of justice is not accepted by the Republican majority control in this House.

The men who came yesterday are in serious trouble. They are in jeopardy, and they had some sense of the fact that they are in jeopardy. But men everywhere are in trouble, and too often they do not know it. Large numbers of men are in trouble, large numbers of families are in trouble, and I hate to continue to be repetitive and quote this article by Lester Thurow, but it is the best summary. It drives straight to the heart of the matter that you are going to find anywhere. Lester Thurow's article that I quoted several times in the past month is an article which appeared September 3, in the Sunday, New York Times just before Labor Day, and he was talking about the state of the working man in the world, not just in America. That article began with a statement that no country without a revolution or military defeat and subsequent occupation has ever experienced such a sharp shift in the distribution of earnings as America has in the last generation. At no other time have median wages of men fallen for more than two decades. Never before have a majority of American workers suffered real wage reductions while the per capita domestic product was advancing.

I read it because it needs to be read over, and over, and other again.

Now here is some parts I have not read and emphasized before. Let me just tell you how Lester Thurow brings this all together and focuses on families and focuses on males. Quote another paragraph that I have not read before although I have entered this entire article into the RECORD:

> Wages of white men are falling slightly faster than those of black men, and the young have been clobbered. Wages are down 25 percent for men 25 to 34 years of age. Median wages for women didn't start to fall until 1989, but are now falling for every group except college-educated women. The pace of decline seems to have doubled in 1994 and early 1995.

This is Lester Thurow, professor of economics at the Massachusetts Institute of Technology, a recognized expert in this area of manpower, the economy, technology, et cetera. He has testified innumerable times before Congress in various committees. Let me just quote two more paragraphs:

Thiry-two percent of all men between 25 and 34 years of age earn less than the amount necessary to keep a family of four above the poverty line. Thirty-two percent of all men between 25 and 34 years of age earn less than the amount necessary to keep a family of four above the poverty line.

Now he is not talking about black males, just black men. He is talking about American men, 34 percent of all American men, black and white. To continue quoting Lester Thurow:

Using the language of capitalism in today's economy children have shifted from being profit centers to being cost centers. To support them parents have to be willing to make large economic sacrifices.

Now listen closely. Men have a strong economic incentive to bail out of family responsibility since, when they do, their real standard of living rises 73 percent, although that of the family left behind falls 42 percent.

Listen carefully. I will repeat it. He is not talking about black males or black men only. Men have a strong economic incentive to bail out of family responsibility since, when they do so, their real standard of living rises 73 percent, although that of the family left behind falls 42 percent.

To continue Lester Thurow, I quote: ''Whether it is fathering a family without being willing to be a father, whether it is divorce and being unwilling to pay alimony or child support, or whether it is being an immigrant from the Third World and after a time failing to send payments to the family back home, men all around the world are opting out. The Japanese seems to be the only exception,'' quoting Lester Thurow. Men all over the world are opting out under the pressure of not having enough wages to take care of families.

Let me just repeat the last paragraph. Whether it is fathering a family without being willing to be a father, whether it is divorce and being unwilling to pay alimony or child support, whether it is being an immigrant from the Third World and after a time failing to send payment to the family back home, men all around the world are opting out. The Japanese seem to be the only exception.

The men who came here yesterday came, and it was advertised as a day of atonement. From the very first this march, called by Louis Farrakhan, it was Farrakhan's march, spoke of a day of atonement for the sins that have been committed against black women and families, a day of atonement for the sins that have been committed. The men came to deal with taking personal responsibility, and that is very important. That is very important. Nobody should minimize the importance of men and women, human beings, taking personal responsibility.

The problem is that in this world there is a government responsibility that is also very much tied to what happens to individuals and what happens to families, and to oversimplify, not understand, that you must change the way your government operates in order to be able to take care of your family, that it is child neglect not to be involved in the political process, it is child neglect and family neglect not to exercise your responsibilities as a citizen and try to change the policies of your government.

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That has to be understood. Medicare and Medicaid are not individual responsibilities, except the way they utilized, and the way individuals pay taxes into a system which helps to support Medicare and Medicaid. But you cannot have your family taken care of properly, with respect to health care, by yourself, no matter how much you reform and change your own lifestyle, which is highly desirable in many

cases, and I am told that the men who came yesterday, the police have remarked that rarely have they seen such an orderly group, such a purposeful group, such a group that was intent on making a good impression, so great things will happen as a result of those individuals who came yesterday. I expect there will be personal changes that are very important.

However, to ignore the Medicare emergency, ignore the Medicaid emergency, to have the leaders not really focus more on the earned income tax credit, the job training, the summer youth employment, the title I cuts, the crime prevention cuts, the drug treatment cuts, to not understand that the economy is shaped by forces that are beyond the control of individuals and families, and to not address the fact that Government policies at this point are at the root of the problems being faced by families and their inability to cope, in many cases.

My evaluation of the Million Man March is mixed. Many people will wonder why I am going out in praise of the young men who came. I agree with the sensitivity expressed by the Daily News editorial, that their intent was magnificent and they came for good reasons. The overall impression is a good one, that made a Martin Luther King on the conscience of America.

I am one of the people who did not support the march. I did not endorse the march. I did not participate. Today, after proclaiming that it made a good impression on the conscience of America, I still have no apologies for not participating. The young men who came, came for various reasons. I know, because I have talked to dozens of them over and over again, over the past 3 months. They have told me.

I would summarize by saying the greatest percentage of them came in order to be a part of the positive energy of so many black males gathered in one place. They wanted to be a part of the positive energy. They wanted to bond with their black brothers. They did not have a political agenda, unfortunately. They also did not have an agenda to support Minister Louis Farrakhan in his endeavors. They were not interested in a philosophy of isolationism. They were not interested in a separatist philosophy. They were not interested in anti-Semitism. The great majority of them did not have that as an agenda.

As a member of the leadership, I could not participate because I knew very well the danger of supporting an activity which is led by a minister, Louis Farrakhan, who refuses, basically, to change his agenda. Let it be clearly understood that I am pleasantly surprised and quite happy and optimistic about the fact that there was a moderate statement made, a moderating statement, a conciliatory statement made, about moving toward unity, about sitting down with people that the Nation of Islam has had differences with, about sitting down with the Jewish community. I think all of that should be applauded. I think it is a great step forward. Blessed are the peacemakers. All of us should look forward to wanting to move through those kinds of hurdles and get over bigotry, racism, and any kind of religious condemnation or anti-Semitism. We should all want to do that. I applaud that, and am happy that it happened.

We have to see, however, how it develops. I did not support the Million Man March, but I respect those leaders who did participate. I consider myself a follower of Martin Luther King, who has taken a totally opposite approach to Minister Louis Farrakhan. Martin Luther King preached integration, not isolation, not segregation. Martin Luther King preached love, Martin Luther King preached moving forward in a positive way to overcome the difficulties of this society. Yet, when he died, he was planning a poor people's march on Washington, so economics was also a concern of Martin Luther King.

That agenda that he had was awesome. Segregation was the major problem. He had gotten around, on to economics, and dealing with a change in the way America does business and the way it treats people, black people in particular, economically, only because he had had to go through such a rigorous agenda on segregation and the violation of civil rights, so it was not because Martin Luther King did not understand the need to address basic problems such as jobs, businesses, and sharing in the great American economy.

I am a follower of Martin Luther King, the way of Martin Luther King, not a way of isolationism or hate or bigotry. There were others who were also followers of Martin Luther King who chose to join the march and participate, other leaders. I certainly think all the young people who participated are not in one category, and there is no question about their choice.

I think the leaders who participated, there is a slight philosophical difference between me and them in terms of those who are followers of Martin Luther King and felt they had to participate and feel that there is a danger in following an isolationist leader, a leader who preaches hate, segregation, et cetera. I respect them, and I do not consider myself as having a monopoly on wisdom.

I went through several stages in reaching the decision that I should not participate in the Million Man March. The Congressional Black Caucus considered whether it should endorse the Million Man March. At that time I led the opposition. I was in favor of issuing a statement by the Caucus which said:

> We welcome all marchers. We certainly want to encourage maximum participation in this political process. We welcome more letter writing to Congressmen, we welcome lobbying, we welcome more petitioning, and above all we welcome more demonstrations and marches.

The Caucus would issue that agenda. For that reason we developed an 11-point program. I offered to the caucus an 11-point program which summarized what is going on here in Washington that all black people ought to be concerned about, which part of this war without blood affects them, which part of this effort to remake America impacts on black people. If you look at the list that I drew up, the 11 points, I think it is pretty well covered there.

I made that argument and I lost. The overwhelming percentage of Caucus Members voted to endorse the march. We do not deal with the numbers and that and so forth, but suffice it to say an overwhelming percentage endorsed the march, and I felt I had to respect that decision. I certainly was not going to go out and campaign against a decision in the Caucus when I had participated in the debate, in the process, but I did tell people that I was not going to participate.

When I was confronted with numerous young people who wanted to participate and other people who wanted to participate, I listened to their arguments and I came to the conclusion that the best recommendation was, to those people who wanted to participate and who had reasons for participating which had nothing to do with a day of atonement for the sins committed against black women and their children or families, they wanted to go for other reasons, of the dozens that I talked to, at least one-quarter of them wanted to go for religious reasons, and they identified with the Nation of Islam's religious agenda.

Another one-quarter did have some political agenda. They understood that Medicare was under attack, that Medicaid was under attack. They understood that programs which had benefited the black community for years were about to be destroyed. They wanted to be a part of the march in order to protest that. At least half of them had no agenda, politically or religious. They wanted to bond with the million men who came. They wanted to be a part of the positive energy.

Given that agenda, I respected it. I told everybody that if they go, they should go and carry their own banner, to say what they are in the march for, give out their own leaflets. I even offered leaflets to people which had the Congressional Black Caucus 11-point agenda. I came to that conclusion, and verbally made that statement to individuals who asked me. I made the same statement to many press people who called.

However, it became obvious that the march was too big, the issues were too great, to just make verbal statements. I prepared a draft of a written statement, and was about to issue that draft last Thursday when several new developments took place that made me revise the draft. My draft, first draft, said that I understood from talking to young black males in my community, I understood from talking to black males in general, that large numbers of people would come and large numbers

of people who could not come to the Million Man March yesterday wanted to come.

I understood their sentiments, and I hoped that with the momentum of the occasion, I hoped that having that many young black males who felt that strongly about their presence being important in Washington, would make Minister Farrakhan rise to the occasion. I said in that statement that I hoped that he would renounce all anti-Semitism, all isolatonism and hostility toward the idea of one world, and the fact that the black community cannot exist alone.

I hoped that he would abandon the philosophy which endangers the black community, that philosophy which makes it appear that somehow blacks can exist alone; no other group has attempted to exist alone, but somehow blacks can go it alone and be hostile toward traditional allies. We do not need allies. History hear clearly shown, a number of studies have shown, that minorities above all need allies. In order for minorities to survive, they must have allies.

Studies have shown that no matter how good a minority may be in terms of measuring up to the standards of the majority, the majority will inevitably, if the minority does not have some protection, turn on the minority. It is not a matter of how good you are and how you measure up to the standards that are set by the majority, the minority is always in danger. The Jews in Germany excelled in many fields, so envy took over and they were in danger, as they were in the inquisition in Spain. There were a number of occasions where the excelling and the measuring up to the standards of a given society did not please the majority. They found some other excuse.

There are blacks who think that what you have to do is measure up to the standards set by whites, get an education, raise your moral standards, do all the things that middle-class America says its values, and automatically the race problem will go away, automatically being a minority will no longer be a problem. That is not what history bears out. If you do that, you will be an object of envy, and the same racism will be there, because majorities behave in that way toward minorities, usually. Usually there is some demagogue who comes along and takes advantage of the fact that there is a minority, and they can use that minority and the persecution of that minority to galvanize the majority.

Minorities are always vulnerable, for that reason. Either you are condemned and treated with contempt and labeled as inferior, as the Bell Curve does, and a number of other respectable scientists and philosophers are attempting to do, and that is the excuse for the oppression of the minority, or you are too rich, too talented, and taking too much of the resources, and therefore, you must be persecuted, so minorities are always in danger.

Only a philosophy which says we are going to continually reach out for allies, we are going to continually try to be less of a minority, and continue to integrate into a larger society of what I call the caring majority. There are people in the world of all colors that we want to identify with, people in the world of all religions that we want to identify with. They label themselves. They become a kind of caring majority that must be joined.

I have used the word ''barbarian'' here many times, and I have had people here recently tell, me ''You are as hostile and militant and uncompromising as some of the people you criticize.'' I use the word ''barbarian'' and I have defined it every time I use it. I say there are high-technology barbarians running the majority here. They are in control. I have defined it, not as the Romans defined barbarian. The Romans defined barbarian as anybody who was not a Roman. I have not defined barbarians in that way. That is a racist definition.

I defined clearly, barbarians are people who have no compassion. They cannot empathize. They have no feeling for anyone except those in their immediate family or their immediate friends, but they cannot feel or have compassion for other people. That is a barbarian. I have defined high-technology barbarians as people who are very bright, people who know how to use communications, modern communications media, people who have computers and know how to use computers, people who have gone to the best colleges. Those are the people who I call the high-technology barbarians.

It has nothing to do with color. There are black high-technology barbarians, there are white high-technology barbarians, there are Jewish high-technology barbarians, there are Protestant, Catholic high-technology barbarians. I define people by conditions they have control over.

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We are not born a barbarian. We can become a barbarian as a result of our own actions and our own attitudes or our own philosophy. Nobody is a barbarian because of the color of their skin or the religion they happen to have adopted. They are barbarians because of their attitudes. When they are public officials and in powerful places, they are dangerous barbarians.

So Mr. Speaker, I want to make it clear that my use of the term is not a racist definition of everybody who is not black, or everybody who is not a Baptist, a Protestant, a Christian. I clearly label barbarians as those who have no compassion, those who would sit and make policies which disenfranchise from health care millions of people and not have any feeling or any compassion in the process. Those are barbarians.

Let me just continue, Mr. Speaker. My first draft appealed to Minister Farrakhan to rise above his own prejudices, his own past agenda of isolationism, and segregationist strategies. I said in that draft that I hoped that he would do that. And then, 3 days before the reports began to come out about the charge of bloodsuckers; that Jews were called bloodsuckers. And when an explanation was sought, it was expanded to not only Jews but Koreans and Arabs and everybody in the black community who takes money out of the black community are bloodsuckers. It looked as if there would be no opportunity to have Minister Farrakhan on the podium rising above the occasion, so I rewrote my draft and did not make an appeal that would look stupid.

I want to enter the entire statement for the record, Mr. Speaker. The statement is labeled ''Statement of Congressman Major Owens on the October 16 Million Man March sponsored by the Nation of Islam''. The statement was issued on Monday morning, October 16, 1995. It has an attachment, which is called ''The fight for the CBC and caring majority agenda''.

The 11 points that I talked about before, in which I said the Congressional Black Caucus should put out as reasons to march, are attached, and I want to enter the statement in its entirety, but let me just read from the statement in a few areas to clarify what I have just said.

My statement on the Million Man March begins as follows:

In my activist bones there is something that makes me always yearn to support a demonstration or a march. Certainly, given the vicious unrelenting attack on public policies which benefit the majority of Blacks, there is an urge to applaud any non-violent action that makes the Gingrich hi-tech barbarians a target. As a manifestation of massive people empowerment a march on Washington by the Caring Majority could be very much in order and long overdue.

But the October 16th march is not a Caring Majority march. Is Minister Louis Farrakhan's march focused on the current outrages of the Washington Republican majority? Is the anger of this march targeted at the pending legislation which will eradicate the entitlement of all poor children, including Black children, to receive Aid For Families with Dependent Children? Are the voices of the organizers denouncing the proposals to eradicate the entitlement for Medicaid? Are the idealistic youth headed for Washington being told that they should vent their rage on those who have cut billions of dollars from low-income housing, job training, education and other vital programs? Unfortunately in most march organizing circles the answer to these questions is ''No''.

Despite my activist instincts I refuse to participate in the October 16th Million Man March because the agenda of the March is purposefully shrouded in contradictions and conflicting messages. As a leader and elected member of Congress I can not endorse and engage in an activity which has leaders who loudly call for ecumenical and united action, but who thrive on autocratic planning and decision-making. I can not agree to blind and unconditional unity with those slogans and platforms have consistently been reckless and divisive. I cannot support a major statement by a group whose continuing isolationist posture and separatist strategy pose a long-term threat to the survival of the African American community.

Those who want to participate should not be denounced or even discouraged. I have talked to several dozen young men who are planning to join the March. One quarter of them clearly see the March as a religious affirmation experience. Approximately one half see it as an opportunity to ''bond'' with males and be a part of a massive generation of ''positive energy''. One fourth state that they are going in order to personally protest the ''political situation''.

Given this obvious intense desire to participate, my advice to these young men has been: If you go carry your own banner and give out your own leaflets to state the reason you are there.

This March is a golden opportunity to send a powerful message to America. But this March is Minister Louis Farrakhan's March. His picture has been on every recruitment poster. Farrakhan will determine who speaks and for how long on the program in Washington. This assemblage in Washington could have been Farrakhan's golden opportunity.

It could have been a golden opportunity. I did not know at that time what would happen. Fortunately, nothing terrible happened in Farrakhan's speech, buy nothing was done to eradicate some of the policies that have been clearly set forth in the past. I am optimistic. I am willing to wait. I hope that the few things that were said in the spirit of conciliation will go forward.

In another part of this statement I say that one problem that is a major problem relates to the fact that as the march progressed, I am quoting from the statement, ''As the march progressed,'' and this happened at a church in Brooklyn. The speech was made by this gentleman. ''As the march progressed, Khalid Muhammed continued to view the march as primarily a religious march with the date chosen to be as near the birthdate of the Honorable Elijah Muhammed as possible. For him this march is still primarily ''a day of atonement for the sins of black men against black women and their families.''

This was taken from a newspaper article which quoted a speech made by Mr. Khalid Muhammed in a church in Brooklyn.

Leadership by an unrepentant Khalid Muhammed emphasizing the presence of Black men in Washington for the purpose of ''atoning'' for their sins is the one certain way to guarantee a dangerous and harmful message from this massive March. Speaker Gingrich and his hi-tech barbarians will welcome such a ''confession'' by Black men. This ''atoning'' validates the repeated Republican attacks on the Black community.

If the sins of Black men are the problem, then 232 years of slavery and a hundred years of brutal oppression after slavery are not part of the problem. If the collective sins of Black men are the major problem, then government policies which have denied economic development to the great cities and generated long-term unemployment for Blacks are not a significant part of the problem.

If the collective sins of Black men are the primary problem, then there is no need to fight the eradication of the entitlement of public assistance for poor children. There is no need to fight the proposals to end the entitlement to health care through medicaid. If sin is the primary problem then government policies and actions have almost no role to play in the struggle to rebuild African American Communities. Sin is the province and responsibility of religions, ministers, churches, mosques, synagogues, temples and other similar groupings. Government only causes confusion and division when it mixes with religion.

Not sin, but public policies, government laws, rules, regulations and actions must be the primary concerns of elected officials and other secular lenders. No one should ever underestimate the role of personal morality in human affairs. We know that individuals are ultimately the masters of their own fates. But it is the duty of government to facilitate human and family positive development. Government and public policies must always strive to remove as many obstacles to ''life, liberty and the pursuit of happiness'' as possible. The Nation of Islam should not oversimplify the problems of our complex society and allow those in power to wash their hands and forget the problems they have created.

Instead of the Congressional Black Caucus endorsing a primarily religious march which had a planning process and an agenda which the Caucus could not influence, I urged the members of the CBC to issue its own agenda for action and invite all interested groups to march and fight for this Caring Majority Agenda.

In the final analysis time, intellect and energy spent denouncing the actions of others represent resources not being most effectively used. Let us leave the Nation of Islam to crusade with its religious focus on sin.

It is for us, the Caring Majority, to define ourselves not merely with words but the mass actions. From coast to coast, throughout this nation, Manifestations of Empowerment must be organized by the Caring Majority with high visibility, and a powerful focus. With representatives from both sexes, all races and ethnic groups, all religions and creeds; in unison with all who care about the expansion of freedom, jobs, justice, and health care, the Caring Majority must move beyond October 16th and seize the initiative. And, as a climactic statement to those in Washington who want to ''remake America'' for the convenience of an oppressive elite minority, the Caring Majority must convene its own assembly of one million persons on the mall in Washington. We shall overcome!

The important thing is now that almost a half million young black males were engaged. I hope they stay engaged. There were some positive things that were recommended by Minister Farrakhan. He told them to go back and join organizations, join churches, adopt one person in jail, register eight voters, pledge not to commit violence themselves against anyone, pledge not to strike women, pledge not to dishonor women.

Mr. Speaker, I think those were agendas for returning that are important. The most important agendas, however, have still to be supplied. Elected officials, whether Congressmen or city councilmen, assembly persons, State Senators must supply that agenda. We must enter the battle for the minds of our young males. They are engaged, we must guarantee that they remain engaged in a constructive way. We must guarantee they understand that a state of emergency exists. It is a political problem, and they must step forward to deal with that problem.

The full text of the statement is as follows:

STATEMENT OF CONGRESSMAN MAJOR R. OWENS ON THE OCTOBER 16 MILLION MAN MARCH SPONSORED BY THE NATION OF ISLAM

In my activist bones there is something that makes me always yearn to support a demonstration or a march. Certainly, given the vicious unrelenting attack on public policies which benefit the majority of Blacks, there is an urge to applaud any nonviolent action that makes the Gingrich hi-tech barbarians a target. As a manifestation of massive people empowerment a march on Washington by the Caring Majority could be very much in order and long overdue.

But the October 16th march is not a Caring Majority march. Is Minister Louis Farrakhan's march focused on the current outrages of the Washington Republican majority? Is the anger of this march targeted at the pending legislation which will eradicate the entitlement of all poor children, including Black children, to receive Aid For Families with Dependent Children? Are the voices of the organizers denouncing the proposals to eradicate the entitlement for Medicaid? Are the idealistic youth headed for Washington being told that they should vent their rage on those who have cut billions of dollars from low-income housing, job training, education and other vital programs? Unfortunately in most march organizing circles the answer to these questions is ''NO''.

Despite my activist instincts I refuse to participate in the October 16th Million Man March because the agenda of the March is purposefully shrouded in contradictions and conflicting messages. As a leader and elected member of Congress I can not endorse and engage in an activity which has leaders who loudly call for ecumenical and united action, but who thrive on autocratic planning and decision-making. I can not agree to blind and unconditional unity with those whose slogans and platforms have consistently been reckless and divisive. I cannot support a major statement by a group whose continuing isolationist posture and separatist strategy pose a long-term threat to the survival of the African American community.

Those who want to participate should not be denounced or even discouraged. I have talked to several dozen young men who are planning to join the March. One quarter of them clearly see the March as a religious affirmation experience. Approximately one half see it as an opportunity to ''bond'' with males and be a part of a massive generation of ''positive energy''. One fourth state that they are going in order to personally protest the ''political situation''.

Given this obvious intense desire to participate, my advice to these young men has been: If you go carry your own banner and give out your own leaflets to state the reason you are there.

This March is a golden opportunity to send a powerful message to America. But this March is Minister Louis Farrakhan's March. His picture has been on every recruitment poster. Farrakhan will determine who speaks and for how long on the program in Washington. This assemblage in Washington could have been Farrakhan's golden opportunity.

Minister Farrakhan could have used this platform to truly unify Black America by endorsing the ideals and principles which place the African American community on the very highest moral ground. Farrakhan could have wiped out the past and taken a great leap forward by following the example of Nelson Mandela and denouncing all racism, sexism, anti-semitism and other religious bigotry, homophobia, prejudice, immigrant bashing and oppression of the poor.

A pledge to cleanse anti-semitism from the Nation of Islam's literature, videos, radio and television scripts would have constituted

a dramatic first step toward the rising of a new sun of unity in the firmament of the Black community. The doors would have been opened wide for the full embracing of our allies among all ethnic, religious, national and economic groups. The Nation of Islam, in unison with the African American Community, would have been able to assume its rightful place as a critical part of the greater Caring Majority.

This March offered a golden opportunity for Minister Farrakhan. But the speeches within the last forty eight hours have indicated that he has chosen to trample on this option for conciliation. Basic steps to establish an environment which rejects bigotry and anti-semitism have been rejected. Farrakhan's speeches trumpeting the charge of ''bloodsuckers'' has grown more shrill. At the same time that Black college professors are working to prepare a more detailed political manifesto, Minister Khalid Muhammad, one of the nation's crudest and most notorious anti-semites, has been given the pivotal role of instructing the young Marchers.

As the march progressed, Khalid Muhammed continued to view this March as primarily a religious one with the date chosen to be as near the birthdate of the Honorable Elijah Muhammed as possible. For him the March is still primarily ''a day of atonement for the sins of Black men against Black women and their families''.

Leadership by an unrepentant Khalid Muhammed emphasizing the presence of Black men in Washington for the purpose of ''atoning'' for their sins is the one way to guarantee a dangerous and harmful message from this massive March. Speaker Gingrich and his hi-tech barbarians will welcome such a ''confession'' by Black men. This ''atoning'' validates the repeated Republican attacks on the Black community.

If the sins of Black men are the problem, then 232 years of slavery and a hundred years of brutal oppression after slavery are not part of the problem. If the collective sins of Black men are the major problem, then government policies which have denied economic development in the great cities and generated long-term unemployment for Blacks are not a significant part of the problem.

If the collective sins of Black men are the primary problem, then there is no need to fight the eradication of the entitlement to public assistance for poor children. There is no need to fight the proposals to end the entitlement to health care through medicaid. If sin is the primary problem then government policies and actions have almost no role to play in the struggle to rebuild African American Communities. Sin is the province and responsibility of religions, ministers, churches, mosques, synagogues, temples and other similar groupings. Government only causes confusion and division when it mixes with religion.

Not sin, but public policies, government laws, rules, regulations and actions must be the primary concerns of elected officials and other secular leaders. No one should ever underestimate the role of personal morality in human affairs. We know that individuals are ultimately the masters of their own fates. But it is the duty of government to facilitate human and family positive development. Government and public policies must always strive to remove as many obstacles to ''life, liberty and the pursuit of happiness'' as possible. The Nation of Islam should not oversimplify the problems of our complex society and allow those in power to wash their hands and forget the problems they have created.

Instead of the Congressional Black Caucus endorsing a primarily religious march which had a planning process and an agenda which the Caucus could not influence, I urged the members of the CBC to issue its own agenda for action and invite all interested groups to march and fight for this Caring Majority Agenda. (See Attached) For the sake of our families and our communities we must never engage in actions that are wasteful and counterproductive. But all Americans must understand that these are desperate times. The oppressive forces in control of the Congress have created a political state of emergency. In support of a Caring Majority Agenda all concerned groups must lobby, write letters, petition, demonstrate, and march!

In the final analysis time, intellect and energy spent denouncing the actions of others represent resources not being most effectively used. Let us leave the Nation of Islam to crusade with its religious focus on sin.

It is for us, the Caring Majority, to define ourselves not merely with words but with mass actions. From coast to coast, throughout this nation, Manifestations of Empowerment must be organized by the Caring Majority with high visibility, and a powerful focus. With representatives from both sexes, all races and ethnic groups, all religions and creeds; in unison with all who care about the expansion of freedom, jobs, justice, and health care, the Caring Majority must move beyond October 16th and seize the initiative. And, as a climactic statement to those in Washington who want to ''remake America'' for the convenience of an oppressive elite minority, the Caring Majority, in the Spring of 1996, must convene its own ''Tianamen Square'' assembly of one million persons on the mall in Washington. We shall overcome!

ATTACHMENT CONGRESSMAN MAJOR R. OWENS' STATEMENT ON THE MILLION MAN MARCH

FIGHT FOR THE CBC AND CARING MAJORITY AGENDA

In support of the Congressional Black Caucus and Caring Majority Agenda we strongly urge all concerned groups to lobby, demonstrate, petition, write letters and march in these critical days ahead when the President will be negotiating with the Republican controlled Congress to save the nation from devastating budget cuts.

Fight Aggressive Racist Attacks in All Forms: the attacks on affirmative action, school desegregation, set asides and the voting rights act. Fight government and unofficial acts which encourage sexism, anti-semitism, homophobia, immigrant persecution or denial of basic rights to any group.

Fight for Education as a national priority. The CBC Alternative Budget demands a 25 per cent increase in funding for education. President Clinton is also proposing a large increase for education. The Summer Youth Employment Program must also be funded. The Republicans have voted zero for next years Summer Youth Employment Programs.

Fight to stop all cuts in Medicaid as well as Medicare. This nation still needs a National Health Insurance Program with universal coverage.

Fight to end the monstrous cuts in HUD programs for low income housing. More than seven billion dollars have already been cut. That is already too much taken from the poorest families in the nation and the homeless.

Fight to support the retention of adequate wages and pensions for the military, federal workers and other public service workers.

Fight to increase the minimum wage, to guarantee the right to organize unions, to end striker replacement and to maintain safe and healthy conditions in the workplace.

Fight to balance the nation's tax burden lowering taxes on families and individuals while forcing corporations to pay their fair share. At present corporations cover only 11 per cent of the tax burden while individuals and families shoulder 44 per cent of the tax load.

Fight for cuts in defense which downsize the CIA, the overseas bases and wasteful weapons.

Fight for an increase in foreign aid to Africa, the Caribbean, Haiti and other third world nations to assist with vital health and education needs.

Fight for increase in funding for youth crime prevention programs and for a decrease in the billions being voted to build prisons.

Fight and unite with the Caring Majority for the retention of Social Security as it is now. Stop moving the age requirement back and stop tampering with the COLAS.

Fight for ourselves—fight for America

Mr. Speaker, I want to close with a quote from the New York Times again. Columnist Russell Baker, a white man, felt very strongly about what happened yesterday. Columnist Russell Baker spoke his mind and I want to quote. I am going to enter the entire article in the RECORD, but I want to quote columnist Russell Baker from the New York Times' October 17 issue in the RECORD.

So it was left to Louis Farrakhan to act. It is hard to say why without speaking realistically of the state of American politics, which has less and less to do with anything of consequence.

Surely somebody of stature, Democrat or Republican, ought to have felt obliged to act long ago. It is hardly a secret that one of the country's most dangerous problems is the increasingly desperate situation of its young black male citizens.

The portrait of a nation in trouble is etched in the statistics on black unemployment rates, black school dropouts, rising imprisonment of young blacks and killings of black youngsters by black youngsters.

When a large portion of a nation's youth is being thrown away, or hustled into prisons, or lowered into graves, it takes a remarkable capacity for indifference to say that, well, it's a pity, but it's not our problem, it's a problem for the black community, black churches, black neighborhood leaders.

It is hard to see how a multiracial nation can avoid damage if its leaders refuse to deal with its gravest problems on ground that they are distinctively problems of race.

☐ 2115

I am quoting from Russell Baker's article in the New York Times today.

Everybody now knows about the problem of the young black male, and nobody with power has done anything about it. To be sure, President Clinton has gone into the occasional black church and made the correct sounds, but where is the highpowered, bipartisan, interracial Presidential commission empowered to recommend executive and legislative action?

Have the leaders of the black community put pressure on White House and Congress to wake up? If so, the pressure has been as that of a feather pillow on the pyramid of Cheops.

Who are the leaders of this black community, anyhow? Are there any, or are they just fictional creations of the media? Maybe the ''black community'' is fictional, too. Why shouldn't it be? After all, there is no such thing as a ''white community,'' no group who can sensibly be called ''white leaders.''

Maybe it is tired old racist thinking to keep talking about a ''black community'' complete with ''black leaders.'' Maybe it makes more sense nowadays to drop all that

separatist language and say, ''There's nobody here but us Americans.''

The Clinton administration was not the first to do nothing about the desperate situation of the young black American. Doing nothing about it has been the unswerving policy of Presidents back as far as Richard Nixon.

Not incidentally, it was Mr. Nixon's so-called southern strategy that rebuilt the Republican party on white hostility to the Democratic record on civil rights. Nor are the dynamic Newt Gingrich conservatives engaged with the problem. The Contract With America may ask us to assume this its blessings will lead one of these days to more secure childhoods, better schooling, better jobs, and a full dinner pail for young black men. But in the meantime, the Contract With America is explicit about the need to cut welfare.

If a single Republican presidential candidate has spoken on the matter that produced the Million Man March, it has been a pianissimo performance. Let's not forget, either, that some kind of action is overdue. Some kind of action was overdue. There was a vacuum to be filled. Politics has declined into a game for overgrown boys and their high-tech toys. You win by finessing reality.

So, finally it was left for Louis Farrakhan to act. It made a lot of people so mad they could spit. That often happens when good people have done nothing.

End of quote by columnist Russell Baker, a white man commenting on the Million Man March.

The full text of the article is as follows:

[The New York Times, Oct. 17, 1995]

HE FILLED A VACUUM

(By Russell Baker)

So it was left to Louis Farrakhan to act. It is hard to say why without speaking realistically of the state of American politics, which has less and less to do with anything of consequence.

Surely somebody of stature, Democrat or Republican, ought to have felt obliged to act long ago. It is hardly a secret that one of the country's most dangerous problems is the increasingly desperate situation of its young black male citizens.

The portrait of a nation in trouble is etched in the statistics on black unemployment rates, black school dropouts, rising imprisonment of young blacks and killings of black youngsters by black youngsters.

When a large portion of a nation's youth is being thrown away, or hustled into prisons, or lowered into graves, it takes a remarkable capacity for indifference to say that, well, it's a pity, but it's not our problem, it's a problem for the black community, black churches, black neighborhood leaders.

It is hard to see how a multiracial nation can avoid damage if its leaders refuse to deal with its gravest problems on ground that they are distinctively problems of race.

This mistake was made by President Eisenhower 40 years ago and swiftly regretted, for Eisenhower was a serious man, serious about government's duties. He tried to avoid the multiracial reality of America in the Arkansas school desegregation crisis by arguing that race passions resided in the human heart, which could not be changed by government action.

When Arkansas's white Governor Faubus proposed to let the white human heart express itself by defying a court desegregation order, however, Eisenhower used the Army to preserve government by law.

Everybody now knows about the problem of the young black male, and nobody with power has done anything about it. To be sure, President Clinton has gone into the occasional black church and made the correct sounds, but where is the high-powered, bipartisan, interracial Presidential commission empowered to recommend executive and legislative action?

Have the leaders of the black community put pressure on White House and Congress to wake up? If so, the pressure has been as that of a feather pillow on the pyramid of Cheops.

Who are the leaders of this black community, anyhow? Are there any, or are they just fictional creations of the media? Maybe the ''black community'' is fictional, too. Why shouldn't it be? After all, there is no such thing as a ''white community,'' no group who can sensibly be called ''white leaders.''

Maybe it is tired old racist thinking to keep talking about a ''black community'' complete with ''black leaders.'' Maybe it makes more sense nowadays to drop all that separatist language and say, ''There's nobody here but us Americans.''

The Clinton Administration is not the first to do nothing about the desperate situation of the young black American. Doing nothing about it has been the unswerving policy of Presidents back as far as Richard Nixon. Not incidentally, it was Mr. Nixon's so-called ''Southern strategy'' that rebuilt the Republican Party on white hostility to the Democratic record on civil rights.

Nor are the dynamic new Gingrich conservatives engaged with the problem. The Contract With America may ask us to assume that its blessings will lead, one of these days, to more secure childhoods, better schooling, better jobs and a full dinner pail for young black men, but in the meantime it is explicit about the need to cut welfare.

If a single Republican Presidential candidate has spoken of the matter that produced the Million Man March, it has been a pianissimo performance.

Let's not forget, either, the fierce and forbidding tetchiness of many black people, which discourages whites from discussing the problem. It is understandable that a politician might ignore the subject entirely when he fears that getting involved may earn him the epithet of''racist.''

Some kind of action was overdue. There was a vacuum to be filled. Politics has declined into a game for overgrown boys and their high-tech toys. You win by finessing reality. So finally it was left for Louis Farrakhan to act. It made a lot of people so mad they could spit. That often happens when good people have done nothing.

MEDICARE AND VA HEALTH BENEFITS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Pennsylvania [Mr. FOX] is recognized for 5 minutes.

Mr. FOX of Pennsylvania. Mr. Speaker, I want to take this opportunity to address the House this evening to address a couple of major issues, not the least of which is the bill we passed today, H.R. 2353, which I was a cosponsor of with the gentleman from Arkansas [Mr. HUTCHINSON] to extend certain VA health and medical care benefits.

We extended the priority care for Persian Gulf veterans, the alcohol and drug abuse care, nursing home care alternatives, health scholarships, and we have also included within that legislation, which received bipartisan support, almost unanimous vote of the House, residential care for homeless and chronically mentally ill veterans, compensated work therapy and therapeutic transitional housing demonstration grants, and homeless veterans pilot programs, along with a displaying of the POW/MIA flag at all of our VA medical health centers, until the President has confirmed to the House and Senate that all the POW's and MIA's are accounted for.

This legislation was part of our committee work and we are happy to see that it was adopted today in the House and now moves on to the Senate.

One of the areas in which the general public has great interest, and especially the seniors who we are trying to protect with Medicare, we have this legislation coming before the House this week. And for those in the House who have been working on this issue for a long time, many others may ask why are you discussing it this year and why are you trying to reform it?

It was only in April that the President's trustees came back to the House and Senate and said that in 7 years, if we do nothing with Medicare, we will actually run out of money to have a Medicare health care system for our seniors.

Medicare is the Nation's primary medical assistance program for seniors and the disabled. It is composed of two parts: Part A, for which an individual automatically qualifies for at age 65. It provides hospital, home health, and skilled nursing facility coverage, and is paid for by payroll taxes. Those taxes go into the hospital trust fund which, by law, serves as the exclusive source of part A funding.

Part B, a voluntary system in which individuals who qualify for part A may choose to enroll, pays for doctor and outpatient service as well as medical equipment costs. It is paid for out of the general fund of our Government and from premiums paid by beneficiaries

At this point, health care costs in the country, Mr. Speaker, are rising about 4 percent a year. But Medicare has been rising at the rate of 10 to 11 percent a year. Anyone can say: How is there such a disparate difference? Why is it that health care is a 4-percent increase and Medicare is going up at 10 percent?

A large part of that is the fraud, abuse, and waste which exists in the Medicare system, unfortunately.

Mr. Speaker, $30 billion a year goes to pay for fraud, abuse, and waste.

Under legislation that is before the House this week that legislation will address for the first time the enforcement, the speeding up of the prosecution of, investigation of fraud abuse and waste that we have in the Medicare system. It will establish through legislation that I cosponsored with the gentleman from Connecticut [Mr. SHAYS] and the gentleman from New Mexico [Mr. SCHIFF], this legislation will in fact increase the penalties and create for the first time the crime of Medicare fraud.

Mr. Speaker, that will go a long way to making sure that our Medicare system will become solvent and will in fact be secure and strengthened for many years to come.

But the other alternatives, which are also important to discuss tonight, Mr. Speaker, offer not only the fee for services, as has been traditional under Medicare, but also offer to beneficiaries the choice of a managed care option or medical savings accounts.

Under the managed care option there could be additional services, such as pharmaceuticals available, hearing aids, dentures, and the like. Under medical savings accounts, we now have an investment of $4,800 per subscriber in Medicare, which under the proposal now before the House could go to $6,700 by the year 2002.

And this increase for medical savings accounts, for the subscriber that does not use all the funds for 1 year, they could either keep the savings, Mr. Speaker, or have it roll over to the next year's medical health care provided.

In addition to providing the option of fee for service, managed care, and also for the medical savings accounts, it would allow providers to establish provider-sponsored organizations that can offer the Medicare Plus option. That would be for doctors or hospitals to provide, as well as the managed care companies, such options for our senior constituents.

It would establish under the legislation a commission to recommend long-term structural changes to preserve, protect, and strengthen Medicare. It would strengthen the Federal efforts, I may have made it very clear, to have the fraud addressed. I said that previously. But it would also create a new trust fund funded from both Medicare and the Federal Treasury to finance teaching hospitals and graduate medical education programs.

I believe, Mr. Speaker, that while the time is running short, I did want to say that to do nothing with Medicare would have us go bankrupt. So, it is important that we Republicans and Democrats work together this week, the House and the Senate together with the executive branch, to make sure that we not only keep a strong Medicare for this generation's seniors, but for seniors that follow so that we have a strong medical system for many years to come.

Thank you Mr. Speaker. I yield back the balance of my time.

DEBATE OMITTED FROM THE RECORD OF THURSDAY, OCTOBER 12, 1995, ON THE OMNIBUS CIVILIAN SCIENCE AUTHORIZATION ACT OF 1995

Mr. CRAMER. Mr. Chairman, will the gentleman yield?

Mr. WAMP. I yield to the gentleman from Alabama.

Mr. CRAMER. Mr. Chairman, I want to quickly point out that, as the gentleman and I both know, our areas have been designated by the National Research Council as likely among the most vulnerable gap areas in the country with the modernization plan and the recommended placement of NEXRADS. The gentleman and I have been so budget-conscious that we have talked about sharing a NEXRAD, if in fact we get that opportunity, as we hope we will, placing it somewhere between our respective districts, so we can in fact protect our citizens, but at the same time save as much money as possible. I wanted the Members to know that is how well we worked together.

Mr. WAMP. Reclaiming my time, Mr. Chairman, it can be in the State of Alabama, as long as it covers Chattanooga and southeast Tennessee adequately. I appreciate that, and commend the gentleman.

Mr. SOUDER. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I commend the gentleman from Alabama. I am a cosponsor of his amendment, and I want to thank the chairman of the committee for his willingness to hold hearings. We appreciate his willingness to work through problems in northeast Indiana, as well as northwest Ohio, and the tri-state region I represent. I also understand we are moving to new radar systems, and I think those changes in science are very important, and will provide more protection.

However, we have gaps in that system. While we are going through those gaps, if we close our local weather service, we are unprotected over the next few years. If we do not have a whole country covered in the radar systems, it becomes more problematic about the weather stations. Our constituents rely greatly on the National Weather Service to provide advanced warnings of tornadoes and other severe storms. Current law prohibits the National Weather Service from closing weather stations unless it can certify that the closing will cause no degradation in the warning service the stations provide to local residents. Without this amendment, that protection would be struck. A few years ago, the city of Kendalville in my district was hit without warning by a tornado that injured 28 people, destroyed 29 buildings, and damaged over 150 businesses and residences. I happen to be very familiar with that, because I was just south of where the tornado was going, heard the warning on the radio, and turned south so I did not get caught in the path.

All of northeast Indiana, as well as at least 30 other areas of this country, now face the prospect of losing their weather service warnings, even though independent experts at the National Research Council recently acknowledged that they face a potential for a degraded service. We in our area, in the current proposals for the new radar system, are covered by four different systems, and it leaves us very vulnerable in the middle of that.

I was also at a fair last summer where a tornado went from western Ohio and came back west, rather than going west to east, and had there not been a weather service in Fort Wayne, they would have had to relay that to Cincinnati, back to Indianapolis, back to Fort Wayne, and this way in minutes they were able to get us to a shelter.

I know in a very personal way 125,000 people in my districts have sent postcards to NOAA with concerns for this. It is very important. There are a couple of concerns. This bill saves $15 million, this amendment, but $35 million additional, I understand, could be saved. I have been working to cut the budget on appropriations bills and will continue to do that, but we also in this bill, I have supported the space program, I supported the space station, I think the chairman of this committee and the subcommittees have done well in battling for science, but if we can have $100 million for space and Russia, we can afford to protect our own citizens in this country.

It is not just a matter of children's lives being lost and the homes being lost and lives; in my case, it is my wife, my children, myself, people who I grew up with and who are friends, and this is far too important to lose in a transition where, overall, the program is very effective, but some lives could be lost by this degradation of service.

Mr. HERGER. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise in strong support of the Cramer amendment. Mr. Chairman, the modernization of the National Weather Service's purpose is to consolidate weather service offices nationwide without jeopardizing the quality of weather service to any region. While I strongly support this goal, weather service users, the public, and elected officials have repeatedly expressed deep concern that the modernization plan might actually degrade services in some regions of the country.

In response to these concerns, Congress enacted Public Law 102–567, which stipulates that the weather service will not close any of its stations without first certifying that doing so will not degrade weather service to the affected region. Mr. Chairman, I have grave concerns about the provisions of this bill that repeal this mandate. No one in this Chamber is more committed to streamlining Government than I am. However, we should not do so at the expense of the safety of the people in northern California and elsewhere in the country. Yet, that is precisely what will happen if we do not adopt the amendment offered by the gentleman from Alabama.

Mr. Chairman, let me illustrate by describing several situations in my own district of northern California.

Presently, the National Weather Service plans to close its office in the city of Redding, the largest population center in California north of Sacramento. This decision has been made despite mountains of credible scientific evidence, including findings by the weather service meteorologists in California, that doing so could have a potentially devastating impact on Redding and the communities further north. The mountains to the north of Redding, including the Interstate 5 corridor, which provides the primary transportation route between Oregon and California, are subject to severe storms that have been the source of some of the worst flooding in California history. Last spring, for example, floods ravaged the 10 counties in my district, leaving each a Federal disaster area. During this tragedy, the weather service in Redding provided critical, up-to-the-minute information to local officials, enabling them to react almost instantaneously to individual emergencies.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. PALLONE) to revise and extend their remarks and include extraneous material:)

Mr. GIBBONS, for 5 minutes, today.

Ms. DELAURO, for 5 minutes, today.

Mr. LEVIN, for 5 minutes, today.

Mr. PALLONE, for 5 minutes, today.

Mrs. CLAYTON, for 5 minutes, today.

Mr. DURBIN, for 5 minutes, today.

Mr. BROWN of Ohio, for 5 minutes, today.

(The following Members (at the request of Mr. HAYWORTH) to revise and extend their remarks and include extraneous material:)

Mr. JONES, for 5 minutes, today.

Mr. CUNNINGHAM, for 5 minutes, today.

Mr. KINGSTON, for 5 minutes, today.

(The following Member (at his own request) to revise and extend his remarks and include extraneous material:)

Mr. DORNAN, for 5 minutes, today.

EXTENSION OF REMARKS

By unanimous consent, permission to revise and extend remarks was granted to:

(The following Members (at the request of Mr. PALLONE) and to include extraneous matter:)

Mr. LANTOS.

Mrs. MALONEY in five instances.

Mr. HALL of Ohio.

Mr. GIBBONS.

Mr. RANGEL.

Mr. TOWNS.

Mrs. SCHROEDER.

Mr. PALLONE.

Mr. HASTINGS.

Mrs. THURMAN.

Mr. FILNER.

Mr. STOKES.

Mr. HAMILTON.

Mr. SCHUMER.

Ms. WOOLSEY.

Mrs. MEEK of Florida.

(The following Members (at the request of Mr. HAYWORTH) and to include extraneous matter:)

Mrs. MORELLA in two instances.

Mr. GINGRICH.

Mr. SHADEGG.

Mrs. VUCANOVICH.

Mr. GALLEGLY.

Mr. KING.

Mr. GREENWOOD.

Mr. CLINGER.

(The following Members (at the request of Mr. FOX of Pennsylvania) and to include extraneous matter:)

Mr. FORBES.

Mr. GILLMOR in two instances.

Mr. DOOLEY.

Mr. OWENS.

Mr. SOLOMON.

Mr. OBERSTAR.

SENATE BILL REFERRED

A bill of the Senate of the following title was taken from the Speaker's table and, under the rule, referred as follows:

S. 1267. An act to amend the Congressional Award Act to revise and extend authorities for the Congressional Award Board; to the Committee on Economic and Educational Opportunities.

ADJOURNMENT

Mr. FOX of Pennsylvania. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 9 o'clock and 22 minutes p.m.), the House adjourned until tomorrow, Wednesday, October 18, 1995, at 10 a.m.

EXPENDITURE REPORTS CONCERNING OFFICIAL FOREIGN TRAVEL

Reports concerning the foreign currencies and U.S. dollars utilized by a committee of the U.S. House of Representatives during the second quarter of 1995, as well as an amendment to the consolidated Speaker's report for the 2nd quarter of 1995 in connection with official foreign travel, pursuant to Public Law 95–384, are as follows:

AMENDED REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, CONSOLIDATED SPEAKER'S REPORT, U.S. HOUSE OF REPRESENTATIVES, MR. DOUGLAS J. LAMUDE, EXPENDED BETWEEN MAY 28 AND JUNE 2, 1995

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Douglas J. Lamude	5/28	6/2	Nigeria	227.01	339.00	60.98	3990.15	1.83	35.00	289.82	4364.15
Committee total					566.01		4051.13		36.83		4653.97

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

DOUGLAS J. LAMUDE, Oct. 2, 1995.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON APPROPRIATIONS, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN APRIL 1 AND JUNE 30, 1995.

Name of Member of employee	Date		Country	Per diem		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency	Foreign currency	U.S. dollar equivalent or U.S. currency	Foreign currency	U.S. dollar equivalent or U.S. currency	Foreign currency	U.S. dollar equivalent or U.S. currency
Hon. Sonny Callahan	4/22	4/25	Belgium		981.00		(3)				981.00
	4/25	4/28	Italy		870.00		(3)				870.00
	4/28	4/30	England		592.00		(3)				592.00
Hon. Norm Dicks	6/8	6/12	France		1,332.00		(3)				1,332.00
Commercial airfare							657.35				657.35
Hon. Steny Hoyer	4/18	4/19	Italy		235.00		(3)				235.00
Hon. Joe Knollenberg	4/22	4/25	Belgium		981.00		(3)				981.00
	4/25	4/28	Italy		870.00		(3)				870.00
	4/28	4/30	England		592.00		(3)				592.00
Hon. Jim Lightfoot	4/22	4/25	Belgium		981.00		(3)				981.00
	4/25	4/28	Italy		870.00		(3)				870.00
	4/28	4/30	England		592.00		(3)				592.00
Hon. John Myers	4/22	4/25	Belgium		981.00		(3)				981.00

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON APPROPRIATIONS, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN APRIL 1 AND JUNE 30, 1995.—Continued

Name of Member of employee	Date		Country	Per diem		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency	Foreign currency	U.S. dollar equivalent or U.S. currency	Foreign currency	U.S. dollar equivalent or U.S. currency	Foreign currency	U.S. dollar equivalent or U.S. currency
	4/25	4/28	Italy		870.00		(3)				870.00
	4/28	4/30	England		592.00		(3)				592.00
Hon. Esteban Torres	4/19	4/20	Ireland		279.00		(3)				279.00
	4/20	4/24	Italy		1,226.00		(3)				1,226.00
	4/24	4/27	Israel		879.00		(3)				879.00
	4/27	4/29	Belgium		729.00		(3)				729.00
Hon. Barbara Vucanovich	4/22	4/25	Belgium		981.00		(3)				981.00
	4/25	4/28	Italy		870.00		(3)				870.00
	4/28	4/29	England		592.00		(3)				592.00
Hon. Roger F. Wicker	4/22	4/25	Belgium		981.00		(3)				981.00
	4/25	4/28	Italy		870.00		(3)				870.00
	4/28	4/29	England		592.00		(3)				592.00
Hon. Charles Wilson	6/10	6/14	France		1,332.00						1,332.00
Commercial air fare							3,354.75				3,354.75
Sally Chadbourne	4/9	4/15	Chile		472.00						472.00
Commercial air fare							1,934.95				1,934.95
Elizabeth C. Dawson	4/22	4/25	Belgium		981.00		(3)				981.00
	4/25	4/28	Italy		870.00		(3)				870.00
	4/28	4/30	England		592.00		(3)				592.00
William Inglee	4/22	4/25	Belgium		981.00		(3)				981.00
Commercial air fare							[4] 484.95				484.95
Frederick G. Mohrman	4/22	4/25	Belgium		981.00		(3)				981.00
	4/25	4/28	Italy		870.00		(3)				870.00
	4/28	4/30	England		592.00		(3)				592.00
Commmittee total					27,009.00		6432.00				33,441.00

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.
[3] Military air transportation.
[4] One-way.

BOB LIVINGSTON,
Chairman, Sept. 27, 1995.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON SURVEYS AND INVESTIGATIONS STAFF, HOUSE COMMITTEE ON APPROPRIATIONS, U.S. HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN APRIL 1 AND JUNE 30, 1995.

Hame of Member of employee	Date		Country	Per diem		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency	Foreign currency	U.S. dollar equivalent or U.S. currency	Foreign currency	U.S. dollar equivalent or U.S. currency	Foreign currency	U.S. dollar equivalent or U.S. currency
Frederick A. Bigden	6/24	7/1	GERMANY		1,042.25		2,612.00		19.04		3,673.29
Joseph R. Fogarty	6/24	6/28	ITALY		725.00		4,116.15		43.36		4,884.51
Walter C. Hersman	6/24	7/1	GERMANY		1,042.25		2,612.00		8.40		3,662.65
Terrence E. Hobbs	4/24	4/28	ITALY		641.00		4,116.15		101.38		4,858.53
Johannah P. O'Keeffe	4/24	4/28	ITALY		641.00		4,116.15		18.96		4,776.11
R.W. Vandergrift, Jr.	4/24	4/28	ITALY		737.50		4,116.15		216.07		5,069.72
Committee total					4,829.00		21,688.60		407.21		26,924.81

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

BOB LIVINGSTON,
Chairman, Sept. 27, 1995.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

1531. A letter from the Secretary of Agriculture, transmitting the annual horse protection enforcement report for fiscal year 1994, pursuant to 15 U.S.C. 1830; to the Committee on Commerce.

1532. A letter from the Administrator, General Services Administration, transmitting a report of a building project survey for Oklahoma City, OK, pursuant to 40 U.S.C. 606(a); to the Committee on Transportation and Infrastructure.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

[Submitted October 16, 1995]

Mr. ARCHER: Committee on Ways and Means. H.R. 2425. A bill to amend title XVIII of the Social Security Act to preserve and reform the Medicare Program; with an amendment (Rept. 104–276, Pt. 1). Referred to the Committee of the Whole House on the State of the Union.

Mr. BLILEY: Committee on Commerce. H.R. 2425. A bill to amend title XVIII of the Social Security Act to preserve and reform the Medicare Program; with an amendment (Rept. 104–276, Pt. 2). Referred to the Committee of the Whole House on the State of the Union.

[Submitted October 17, 1995]

Mr. YOUNG of Alaska: Committee on Resources. H.R. 1508. A bill to require the transfer of title to the District of Columbia of certain real property in Anacostia Park to facilitate the construction of National Children's Island, a cultural, educational, and family-oriented park; with an amendment (Rept. 104–277, Pt. 1). Referred to the Committee of the Whole House on the State of the Union.

Mr. GOODLING: Committee on Economic and Educational Opportunities. H.R. 1114. A bill to authorize minors who are under the child labor provisions of the Fair Labor Standards Act of 1938 and who are under 18 years of age to load materials into balers and compacters that meet appropriate American National Standards Institute design safety standards; with an amendment (Rept. 104–278). Referred to the Committee of the Whole House on the State of the Union.

Ms. PRYCE: Committee on Rules. House Resolution 237. Resolution providing for consideration of the bill (H.R. 2259) to disapprove certain sentencing guideline amendments (Rept. 104–279). Referred to the House Calendar.

Mr. KASICH: Committee on the Budget. H.R. 2491. A bill, the 7-year balanced budget reconciliation act of 1995 (Rept. 104–280). Referred to the Committee of the Whole House on the State of the Union.

DISCHARGE OF COMMITTEES

Under clause 5 of rule x, the following action was taken by the Speaker:

[Submitted October 16, 1995]

H.R. 2425. The Committees on the Judiciary and Rules discharged from further consideration.

[Submitted October 17, 1995]

H.R. 1508. The Committee on Government Reform and Oversight discharged from further consideration. H.R. 1508 referred to the Committee of the Whole House on the State of the Union.

TIME LIMITATION OF REFERRED BILL

Pursuant to clause 5 of rule X the following action was taken by the Speaker:

[Submitted October 16, 1995]

H.R. 2425. Referral to the Committees on the Judiciary and Rules extended for a period ending not later than October 16, 1995.

[Submitted October 17, 1995]

H.R. 1508. Referral to the Committee on Government Reform and Oversight extended for a period ending not later than October 17, 1995.

PUBLIC BILLS AND RESOLUTIONS

Under clause 5 of rule X and clause 4 of rule XXII, public bills and resolutions were introduced and severally referred as follows:

By Mr. HOKE (for himself, Mr. HYDE, Mr. LIVINGSTON, Mr. SPENCE, Mr. DELAY, Mr. BOEHNER, Mr. COX, Mr. STUMP, Mr. DORNAN, Mr. HUNTER, Mr. CUNNINGHAM, Mr. ROHRABACHER, Mr. ROYCE, Mr. BARR, Mr. BONO, Mr. FUNDERBURK, Mr. JONES, Mr. SHADEGG, Mr. SMITH of Texas, and Mr. HANSEN):

H.R. 2483. A bill to require the President to give notice of the intention of the United States to withdraw from the Anti-Ballistic Missile Treaty, and for other purposes; to the Committee on International Relations, and in addition to the Committee on National Security, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. MINGE:

H.R. 2484. A bill to amend the Clean Air Act to modify the reformulated gas program; to the Committee on Commerce.

By Mr. ARCHER (for himself, Mr. BLILEY, Mr. BILIRAKIS, Mr. THOMAS, Mr. HYDE, Mr. GREENWOOD, Mr. HASTERT, Mrs. JOHNSON of Connecticut, and Mr. MCCRERY):

H.R. 2485. A bill to amend title XVIII of the Social Security Act to preserve and reform the Medicare Program; to the Committee on Ways and Means, and in addition to the Committees on Commerce, the Judiciary, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. PETERSON of Minnesota:

H.R. 2486. A bill to amend title XVIII of the Social Security Act to preserve and reform the Medicare Program; to the Committee on Ways and Means, and in addition to the Committees on Commerce, the Judiciary, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. ROSE:

H.R. 2487. A bill to amend title 5, United States Code, to allow periods of certain service performed as an employee under certain Federal-State cooperative programs to be creditable for purposes of civil service retirement; to the Committee on Government Reform and Oversight, and in addition to the Committees on Agriculture, and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. SCHIFF:

H.R. 2488. A bill to amend title 18, United States Code, to provide appropriate remedies with respect to prison conditions; to the Committee on the Judiciary.

By Mrs. VUCANOVICH:

H.R. 2489. A bill to amend title XVIII of the Social Security Act to provide for coverage under the Medicare Program of certain additional oral anticancer drugs; to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. HAYWORTH (for himself, Mr. PASTOR, and Mr. KOLBE):

H.R. 2490. A bill to provide for the transfer of certain lands to the Salt River Pima-Maricopa Indian Community and the city of Scottsdale, AZ, and for other purposes; to the Committee on Resources, and in addition to the Committee on Banking and Financial Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. MOLLOHAN (for himself and Mr. BARTLETT of Maryland):

H.J. Res. 113. Joint resolution granting the consent of Congress to the compact to provide for joint natural resource management and enforcement of laws and regulations pertaining to natural resources and boating at the Jennings Randolph Lake Project lying in Garrett County, MD, and Mineral County, WV, entered into between the States of West Virginia and Maryland; to the Committee on the Judiciary.

By Mr. GOODLING:

H. Con. Res. 108. Concurrent resolution to correct technical errors in the enrollment of the bill H.R. 1594; considered and agreed to.

MEMORIALS

Under clause 4 of rule XXII, memorials were presented and referred as follows:

165. By the SPEAKER: Memorial of the Legislature of the State of California, relative to homebased business; to the Committee on Economic and Educational Opportunities.

166. Also, memorial of the Legislature of the State of California, relative to Domestic Violence Awareness Month; to the Committee on Economic and Educational Opportunities.

167. Also, memorial of the Legislature of the State of California, relative to air pollution; to the Committee on Commerce.

168. Also, memorial of the Legislature of the State of California, relative to the Federal Clean Air Act; to the Committee on Commerce.

169. Also, memorial of the Legislature of the State of California, relative to a nonmotorized facility in the Tahoe Basin; to the Committee on Resources.

170. Also, memorial of the Legislature of the State of California, relative to Yosemite National Park; to the Committee on Resources.

171. Also, memorial of the Legislature of the State of California, relative to immigration; to the Committee on the Judiciary.

172. Also, memorial of the Legislature of the State of California, relative to airline ticket commission levels; to the Committee on the Judiciary.

173. Also, memorial of the Legislature of the State of California, relative to the Federal role in transportation; to the Committee on Transportation and Infrastructure.

174. Also, memorial of the Legislature of the State of California, relative to Korean war veterans; to the Committee on Veterans' Affairs.

175. Also, memorial of the Legislature of the State of California, relative to commemorating the 50th anniversary of Victory Over Japan Day; to the Committee on Veterans' Affairs.

ADDITIONAL SPONSORS

Under clause 4 of rule XXII, sponsors were added to public bills and resolutions as follows:

H.R. 117: Mr. HOKE, Mr. WATTS of Oklahoma, Mr. LAHOOD, Mrs. ROUKEMA, Mr. TATE, Mr. WAMP, and Mr. LATOURETTE.

H.R. 127: Mr. DUNCAN, Mr. HUNTER, and Mr. MCDADE.

H.R. 218: Mr. BLILEY.

H.R. 353: Miss COLLINS of Michigan.

H.R. 359: Mr. YOUNG of Alaska.

H.R. 528: Mr. FAZIO of California, Mr. WALSH, Mr. LAHOOD, Mr. DEFAZIO, Mr. SAM JOHNSON, Miss COLLINS of Michigan, Mr. ZELIFF, Mr. LAFALCE, Mr. MFUME, Mr. FIELDS of Texas, Mrs. LOWEY, and Mr. GENE GREEN of Texas.

H.R. 682: Mr. GOODLATTE.

H.R. 705: Mr. SHADEGG.

H.R. 752: Mr. ROMERO-BARCELO.

H.R. 789: Mr. WHITE and Mr. FRANKS of Connecticut.

H.R. 899: Mr. MARTINI.

H.R. 910: Mr. OWENS, Ms. ROYBAL-ALLARD, and Mr. MEEHAN.

H.R. 941: Mrs. MEEK of Florida.

H.R. 997: Mr. BREWSTER, Mr. BROWN of California, Mr. HAYES, Mr. SCHIFF, Mr. STOCKMAN, Mr. TATE, Mrs. THURMAN, and Mr. WHITFIELD.

H.R. 1023: Mr. OWENS, Mr. JEFFERSON, Mr. EHLERS, and Mr. MILLER of California.

H.R. 1127: Mr. ANDREWS, Mr. MCCOLLUM, and Mr. RANGEL.

H.R. 1202: Mr. GUNDERSON, Mr. WOLF, Mr. DAVIS, and Mr. SCHIFF.

H.R. 1278: Mr. FOGLIETTA and Mr. STARK.

H.R. 1493: Mr. FOGLIETTA.

H.R. 1499: Mr. HASTERT and Mr. THORNBERRY.

H.R. 1500: Mr. DICKS and Mr. DURBIN.

H.R. 1589: Mr. HERGER and Mr. SENSENBRENNER.

H.R. 1626: Mr. WELDON of Florida and Mr. MICA.

H.R. 1627: Mr. SMITH of Texas and Ms. PRYCE.

H.R. 1651: Mr. ANDREWS.

H.R. 1684: Mrs. KENNELLY, Mr. GENE GREEN of Texas, and Mr. ORTON.

H.R. 1701: Ms. FURSE.

H.R. 1711: Mr. STOCKMAN and Mr. DAVIS.

H.R. 1713: Mr. FAZIO of California.

H.R. 1757: Mr. FOGLIETTA and Ms. SLAUGHTER.

H.R. 1758: Mrs. THURMAN and Mr. PALLONE.

H.R. 1796: Mr. CALVERT, Mr. INGLIS of South Carolina, Mr. BLILEY, and Mr. HANCOCK.

H.R. 1803: Mr. FARR.

H.R. 1834: Mr. ARCHER, Mr. BATEMAN, Mr. CRANE, Mr. DUNCAN, and Mr. HUNTER.

H.R. 1863: Mr. LUTHER and Mr. JOHNSTON of Florida.

H.R. 1876: Mr. MCDERMOTT, Mr. NADLER, Mr. WAXMAN, Mr. ENGEL, and Ms. RIVERS.

H.R. 1965: Mr. BACHUS, Mr. WATT of North Carolina, Mr. BONIOR, Mrs. ROUKEMA, Mr. FOLEY, Mrs. KENNELLY, and Ms. SLAUGHTER.

H.R. 1968: Ms. MOLINARI.
H.R. 2013: Mr. HOKE.
H.R. 2024: Mr. EWING, Mr. SCHAEFER, Mr. SENSENBRENNER, and Mr. STUPAK.
H.R. 2029: Mr. CONDIT.
H.R. 2137: Mr. WALSH and Mr. HOKE.
H.R. 2148: Mrs. KELLY, Mr. BONO, and Mr. SMITH of Michigan.
H.R. 2178: Mr. BONIOR and Mr. MASCARA.
H.R. 2190: Mr. GORDON, Mr. LEWIS of Kentucky, Mr. FOX, Mr. BEVILL, Mr. BARR, Mr. MOORHEAD, Mr. LIPINSKI, Mr. BONILLA, Mr. RADANOVICH, Mr. HEFLEY, Mr. LEWIS of Georgia, Mrs. KELLY, Mr. BONIOR, Mr. JONES, Mr. SAXTON, Mr. SKEEN, Mr. DORNAN, Mr. SOLOMON, Mr. RAHALL, Mr. HORN, and Mr. BOUCHER.
H.R. 2240: Mrs. MEYERS of Kansas, Ms. SLAUGHTER, and Ms. FURSE.
H.R. 2286: Mr. HUNTER.
H.R. 2339: Mr. STENHOLM.
H.R. 2364: Mr. BARTLETT of Maryland, Mr. FUNDERBURK, and Mr. SKEEN.
H.R. 2374: Mr. FARR and Mr. LEWIS of Georgia.
H.R. 2411: Ms. MCKINNEY and Mr. THORNBERRY.
H.R. 2429: Mr. PETERSON of Minnesota.
H.R. 2435: Mr. TALENT, Mr. ROHRABACHER, Mr. BURTON of Indiana, Mr. MCHUGH, Mrs SMITH of Washington, and Mr. FILNER.
H.R. 2468: Mr. ROGERS and Mr. STENHOLM.
H.J. Res. 64: Mr. SHADEGG.
H.J. Res. 70: Miss COLLINS of Michigan.
H.J. Res. 100: Mr. DIXON, Mrs. MYRICK, Mr. RICHARDSON, and Mr. ROYCE.
H.J. Res. 109: Mr. MOORHEAD, Mr. HORN, Mr. ROYCE, Mr. DORNAN, Mr. LIPINSKI, Mr. CALVERT, and Mrs. CHENOWETH.
H. Con. Res. 50: Ms. ROYBAL-ALLARD.
H. Con. Res. 95: Mr. ACKERMAN, Mr. SAXTON, Mr. BERMAN, Mr. FROST, Ms. ROYBAL-ALLARD, Mr. LIPINSKI, Mrs. SCHROEDER, Mr. MARKEY, Mr. TAYLOR of North Carolina, Mr. UNDERWOOD, Mrs. MEYERS of Kansas, Mr. MCNULTY, and Mr. PORTER.
H.J. Res. 39: Mr. FOGLIETTA.
H.J. Res. 214: Mr. SMITH of Michigan, Mr. HAYWORTH, Mr. BENTSEN, Mr. GANSKE, Mr. SANFORD, Mr. STUPAK, Mr. FOX, and Mr. CANADY.

DELETIONS OF SPONSORS FROM PUBLIC BILLS AND RESOLUTIONS

Under clause 4 of rule XXII, sponsors were deleted from public bills and resolutions as follows:

H.R. 2066: Mr. MILLER of California.

AMENDMENTS

Under clause 6 of rule XXIII, proposed amendments were submitted as follows:

H.R. 39

OFFERED BY: MR. GOSS

AMENDMENT NO. 2: Page 29, line 3, add ''and'' after the semicolon.

Page 29, strike lines 4 through 7 (and redesignate the subsequent paragraph accordingly).

H.R. 39

OFFERED BY: MR. TRAFICANT

AMENDMENT NO. 3: At the end of the bill, add the following new section:

SEC. . SENSE OF CONGRESS; REQUIREMENT REGARDING NOTICE.

(a) IN GENERAL.—Title IV, as amended by section 19, is further amended by adding at the end the following new section:

''SEC. 402. SENSE OF CONGRESS; NOTICE TO RECIPIENTS OF ASSISTANCE.

''(a) PURCHASE OF AMERICAN-MADE EQUIPMENT AND PRODUCTS.—It is the sense of the Congress that, to the greatest extent practicable, all equipment and products purchased with funds made available under this Act should be American-made.

''(b) NOTICE TO RECIPIENTS OF ASSISTANCE.—In providing financial assistance under this Act, the Secretary, to the greatest extent practicable, shall provide to each recipient of the assistance a notice describing the statement made in subsection (a) by the Congress.''.

(b) CLERICAL AMENDMENT.—The table of contents in the first section, as amended by section 19, is further amended by adding at the end the following:

''Sec. 402. Sense of Congress; notice to recipients of assistance.''.

H.R. 2425

OFFERED BY: MR. ARCHER

(Amendment in the Nature of a Substitute)

AMENDMENT NO. 1: Strike all after the enacting clause and insert the following:

SECTION 1. PURPOSE.

The purpose of this Act is to reform the medicare program, in order to preserve and protect the financial stability of the program.

TITLE XV—MEDICARE

SEC. 15000. SHORT TITLE OF TITLE; AMENDMENTS AND REFERENCES TO OBRA; TABLE OF CONTENTS OF TITLE.

(a) SHORT TITLE.—This title may be cited as the ''Medicare Preservation Act of 1995''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) REFERENCES TO OBRA.—In this title, the terms ''OBRA–1986'', ''OBRA–1987'', ''OBRA–1989'', ''OBRA–1990'', and ''OBRA–1993'' refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

(d) TABLE OF CONTENTS OF TITLE.—The table of contents of this title is as follows:

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1804 the following new section:

''PROVIDING FOR CHOICE OF COVERAGE

''SEC. 1805. (a) CHOICE OF COVERAGE.—

''(1) IN GENERAL.—Subject to the provisions of this section, every individual who is entitled to benefits under part A and enrolled

under part B shall elect to receive benefits under this title through one of the following:

''(A) THROUGH FEE-FOR-SERVICE SYSTEM.—Through the provisions of parts A and B.

''(B) THROUGH A MEDICAREPLUS PRODUCT.—Through a MedicarePlus product (as defined in paragraph (2)), which may be—

''(i) a high deductible/medisave product (and a contribution into a MedicarePlus medical savings account (MSA)),

''(ii) a product offered by a provider-sponsored organization,

''(iii) a product offered by an organization that is a union, Taft-Hartley plan, or association, or

''(iv) a product providing for benefits on a fee-for-service or other basis.

''(2) MEDICAREPLUS PRODUCT DEFINED.—For purposes this section and part C, the term 'MedicarePlus product' means health benefits coverage offered under a policy, contract, or plan by a MedicarePlus organization (as defined in section 1851(a)) pursuant to and in accordance with a contract under section 1858.

''(3) TERMINOLOGY RELATING TO OPTIONS.—For purposes of this section and part C—

''(A) NON-MEDICARE-PLUS OPTION.—An individual who has made the election described in paragraph (1)(A) is considered to have elected the 'Non-MedicarePlus option'.

''(B) MEDICAREPLUS OPTION.—An individual who has made the election described in paragraph (1)(B) to obtain coverage through a MedicarePlus product is considered to have elected the 'MedicarePlus option' for that product.

''(b) SPECIAL RULES.—

''(1) RESIDENCE REQUIREMENT.—Except as the Secretary may otherwise provide, an individual is eligible to elect a MedicarePlus product offered by a MedicarePlus organization only if the organization in relation to the product serves the geographic area in which the individual resides.

''(2) AFFILIATION REQUIREMENTS FOR CERTAIN PRODUCTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), an individual is eligible to elect a MedicarePlus product offered by a limited enrollment MedicarePlus organization (as defined in section 1852(c)(4)(E)) only if—

''(i) the individual is eligible under section 1852(c)(4) to make such election, and

''(ii) in the case of a MedicarePlus organization that is a union sponsor or a Taft-Hartley sponsor (as defined in section 1852(c)(4)), the individual elected under this section a MedicarePlus product offered by the sponsor during the first enrollment period in which the individual was eligible to make such election with respect to such sponsor.

''(B) NO REELECTION AFTER DISENROLLMENT FOR CERTAIN PRODUCTS.—An individual is not eligible to elect a MedicarePlus product offered by a MedicarePlus organization that is a union sponsor or a Taft-Hartley sponsor if the individual previously had elected a MedicarePlus product offered by the organization and had subsequently discontinued to elect such a product offered by the organization.

''(3) SPECIAL RULE FOR CERTAIN ANNUITANTS.—An individual is not eligible to elect a high deductible/medisave product if the individual is entitled to benefits under chapter 89 of title 5, United States Code, as an annuitant or spouse of an annuitant.

''(c) PROCESS FOR EXERCISING CHOICE.—

''(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

''(2) EXPEDITED IMPLEMENTATION.—The Secretary shall establish the process of electing coverage under this section during the transition period (as defined in subsection (e)(1)(B)) in such an expedited manner as will permit such an election for MedicarePlus products in an area as soon as such products become available in that area.

''(3) COORDINATION THROUGH MEDICARE-PLUS ORGANIZATIONS.—

''(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a MedicarePlus product offered by a MedicarePlus organization to make such election through the filing of an appropriate election form with the organization.

''(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a MedicarePlus product offered by a MedicarePlus organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

''(4) DEFAULT.—

''(A) INITIAL ELECTION.—

''(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the Non-MedicarePlus option.

''(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary shall establish procedures under which individuals who are enrolled with a MedicarePlus organization at the time of the initial election period and who fail to elect to receive coverage other than through the organization are deemed to have elected an appropriate MedicarePlus product offered by the organization.

''(B) CONTINUING PERIODS.—An individual who has made (or deemed to have made) an election under this section is considered to have continued to make such election until such time as—

''(i) the individual changes the election under this section, or

''(ii) a MedicarePlus product is discontinued, if the individual had elected such product at the time of the discontinuation.

''(5) AGREEMENTS WITH COMMISSIONER OF SOCIAL SECURITY TO PROMOTE EFFICIENT ADMINISTRATION.—In order to promote the efficient administration of this section and the MedicarePlus program under part C, the Secretary may enter into an agreement with the Commissioner of Social Security under which the Commissioner performs administrative responsibilities relating to enrollment and disenrollment in MedicarePlus products under this section.

''(d) PROVISION OF BENEFICIARY INFORMATION TO PROMOTE INFORMED CHOICE.—

''(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to disseminate broadly information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options. Such information shall be made available on such a timely basis (such as 6 months before the date an individual would first attain eligibility for medicare on the basis of age) as to permit individuals to elect the MedicarePlus option during the initial election period described in subsection (e)(1).

''(2) USE OF NONFEDERAL ENTITIES.—The Secretary shall, to the maximum extent feasible, enter into contracts with appropriate non-Federal entities to carry out activities under this subsection.

''(3) SPECIFIC ACTIVITIES.—In carrying out this subsection, the Secretary shall provide for at least the following activities in all areas in which MedicarePlus products are offered:

''(A) INFORMATION BOOKLET.—

''(i) IN GENERAL.—The Secretary shall publish an information booklet and disseminate the booklet to all individuals eligible to elect the MedicarePlus option under this section during coverage election periods.

''(ii) INFORMATION INCLUDED.—The booklet shall include information presented in plain English and in a standardized format regarding—

''(I) the benefits (including cost-sharing) and premiums for the various MedicarePlus products in the areas involved;

''(II) the quality of such products, including consumer satisfaction information; and

''(III) rights and responsibilities of medicare beneficiaries under such products.

''(iii) PERIODIC UPDATING.—The booklet shall be updated on a regular basis (not less often than once every 12 months) to reflect changes in the availability of MedicarePlus products and the benefits and premiums for such products.

''(B) TOLL-FREE NUMBER.—The Secretary shall maintain a toll-free number for inquiries regarding MedicarePlus options and the operation of part C.

''(C) GENERAL INFORMATION IN MEDICARE HANDBOOK.—The Secretary shall include information about the MedicarePlus option provided under this section in the annual notice of medicare benefits under section 1804.

''(e) COVERAGE ELECTION PERIODS.—

''(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION.—

''(A) IN GENERAL.—In the case of an individual who first becomes entitled to benefits under part A and enrolled under part B after the beginning of the transition period (as defined in subparagraph (B)), the individual shall make the election under this section during a period (of a duration and beginning at a time specified by the Secretary) at the first time the individual both is entitled to benefits under part A and enrolled under part B. Such period shall be specified in a manner so that, in the case of an individual who elects a MedicarePlus product during the period, coverage under the product becomes effective as of the first date on which the individual may receive such coverage.

''(B) TRANSITION PERIOD DEFINED.—In this subsection, the term 'transition period' means, with respect to an individual in an area, the period beginning on the first day of the first month in which a MedicarePlus product is first made available to individuals in the area and ending with the month preceding the beginning of the first annual, coordinated election period under paragraph (3).

''(2) DURING TRANSITION PERIOD.—Subject to paragraph (6)—

''(A) CONTINUOUS OPEN ENROLLMENT INTO A MEDICARE-PLUS OPTION.—During the transition period, an individual who is eligible to make an election under this section and who has elected the non-MedicarePlus option may change such election to a MedicarePlus option at any time.

''(B) OPEN DISENROLLMENT BEFORE END OF TRANSITION PERIOD.—

''(i) IN GENERAL.—During the transition period, an individual who has elected a MedicarePlus option for a MedicarePlus product may change such election to another MedicarePlus product or to the non-MedicarePlus option.

''(ii) SPECIAL RULE.—During the transition period, an individual who has elected a high deductible/medisave product may not change such election to a MedicarePlus product that is not a high deductible/medisave product unless the individual has had such election in effect for 12 months.

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—

''(A) IN GENERAL.—Subject to paragraph (5), each individual who is eligible to make

an election under this section may change such election during annual, coordinated election periods.

''(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a calendar year (beginning with 1998), the month of October before such year.

''(C) MEDICAREPLUS HEALTH FAIR DURING OCTOBER, 1996.—In the month of October, 1996, the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform individuals, who are eligible to elect MedicarePlus products, about such products and the election process provided under this section (including the annual, coordinated election periods that occur in subsequent years).

''(4) SPECIAL 90-DAY DISENROLLMENT OPTION.—

''(A) IN GENERAL.—In the case of the first time an individual elects a MedicarePlus option (other than a high deductible/medisave product) under this section, the individual may discontinue such election through the filing of an appropriate notice during the 90-day period beginning on the first day on which the individual's coverage under the MedicarePlus product under such option becomes effective.

''(B) EFFECT OF DISCONTINUATION OF ELECTION.—An individual who discontinues an election under this paragraph shall be deemed at the time of such discontinuation to have elected the Non-MedicarePlus option.

''(5) SPECIAL ELECTION PERIODS.—An individual may discontinue an election of a MedicarePlus product offered by a MedicarePlus organization other than during an annual, coordinated election period and make a new election under this section if—

''(A) the organization's or product's certification under part C has been terminated or the organization has terminated or otherwise discontinued providing the product;

''(B) in the case of an individual who has elected a MedicarePlus product offered by a MedicarePlus organization, the individual is no longer eligible to elect the product because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of membership in a qualified association in the case of a product offered by a qualified association or termination of the individual's enrollment on the basis described in clause (i) or (ii) section 1852(c)(3)(B));

''(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

''(i) the organization offering the product substantially violated a material provision of the organization's contract under part C in relation to the individual and the product; or

''(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the product's provisions in marketing the product to the individual; or

''(D) the individual meets such other conditions as the Secretary may provide.

''(6) SPECIAL RULE FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCTS.—Notwithstanding the previous provisions of this subsection, an individual may elect a high deductible/medisave product only during an annual, coordinated election period described in paragraph (3)(B) or during the month of October, 1996.

''(f) EFFECTIVENESS OF ELECTIONS.—

''(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may provide (consistent with section 1838) in order to prevent retroactive coverage.

''(2) DURING TRANSITION; 90-DAY DISENROLLMENT OPTION.—An election of coverage made under subsection (e)(2) and an election to discontinue a MedicarePlus option under subsection (e)(4) at any time shall take effect with the first calendar month following the date on which the election is made.

''(3) ANNUAL, COORDINATED ELECTION PERIOD AND MEDISAVE ELECTION.—An election of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B)) in a year or for a high deductible/medisave product shall take effect as of the first day of the following year.

''(4) OTHER PERIODS.—An election of coverage made during any other period under subsection (e)(5) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

''(g) EFFECT OF ELECTION OF MEDICAREPLUS OPTION.—Subject to the provisions of section 1855(f), payments under a contract with a MedicarePlus organization under section 1858(a) with respect to an individual electing a MedicarePlus product offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual.

''(h) ADMINISTRATION.—

''(1) IN GENERAL.—This part and sections 1805 and 1876 shall be administered through an operating division (A) that is established or identified by the Secretary in the Department of Health and Human Services, (B) that is separate from the Health Care Financing Administration, and (C) the primary function of which is the administration of this part and such sections. The director of such division shall be of equal pay and rank to that of the individual responsible for overall administration of parts A and B.

''(2) TRANSFER AUTHORITY.—The Secretary shall transfer such personnel, administrative support systems, assets, records, funds, and other resources in the Health Care Financing Administration to the operating division referred to in paragraph (1) as are used in the administration of section 1876 and as may be required to implement the provisions referred to in such paragraph promptly and efficiently.''.

SEC. 15002. MEDICAREPLUS PROGRAM.

(a) IN GENERAL.—Title XVIII is amended by redesignating part C as part D and by inserting after part B the following new part:

''PART C—PROVISIONS RELATING TO MEDICAREPLUS

''REQUIREMENTS FOR MEDICAREPLUS ORGANIZATIONS; HIGH DEDUCTIBLE/MEDISAVE PRODUCTS

''SEC. 1851. (a) MEDICAREPLUS ORGANIZATION DEFINED.—In this part, subject to the succeeding provisions of this section, the term 'MedicarePlus organization' means a public or private entity that is certified under section 1857 as meeting the requirements and standards of this part for such an organization.

''(b) ORGANIZED AND LICENSED UNDER STATE LAW.—

''(1) IN GENERAL.—A MedicarePlus organization shall be organized and licensed under State law to offer health insurance or health benefits coverage in each State in which it offers a MedicarePlus product.

''(2) EXCEPTION FOR UNION AND TAFT-HARTLEY SPONSORS.—Paragraph (1) shall not apply to an MedicarePlus organization that is a union sponsor or a Taft-Hartley sponsor (as defined in section 1852(c)(4)).

''(3) EXCEPTION FOR PROVIDER-SPONSORED ORGANIZATIONS.—Paragraph (1) shall not apply to a MedicarePlus organization that is a provider-sponsored organization (as defined in section 1854(a)) except to the extent provided under section 1857(c).

''(4) EXCEPTION FOR QUALIFIED ASSOCIATIONS.—Paragraph (1) shall not apply to a MedicarePlus organization that is a qualified association (as defined in section 1852(c)(4)(C)).

''(c) PREPAID PAYMENT.—A MedicarePlus organization shall be compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

''(d) ASSUMPTION OF FULL FINANCIAL RISK.—The MedicarePlus organization shall assume full financial risk on a prospective basis for the provision of the health care services (other than hospice care) for which benefits are required to be provided under section 1852(a)(1), except that the organization—

''(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds $5,000 in any year,

''(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

''(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

''(4) may make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

In the case of a MedicarePlus organization that is a union sponsor (as defined in section 1852(c)(4)(A)), Taft-Hartley sponsor (as defined in section 1852(c)(4)(B)), a qualified association (as defined in section 1852(c)(4)(C)), this subsection shall not apply with respect to MedicarePlus products offered by such organization and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization (as defined in section 1854(a)).

''(e) PROVISION AGAINST RISK OF INSOLVENCY.—

''(1) IN GENERAL.—Each MedicarePlus organization shall meet standards under section 1856 relating to the financial solvency and capital adequacy of the organization. Such standards shall take into account the nature and type of MedicarePlus products offered by the organization.

''(2) TREATMENT OF UNION AND TAFT-HARTLEY SPONSORS.—An entity that is a union sponsor or a Taft-Hartley sponsor is deemed to meet the requirement of paragraph (1).

''(3) TREATMENT OF CERTAIN QUALIFIED ASSOCIATIONS.—An entity that is a qualified association is deemed to meet the requirement of paragraph (1) with respect to MedicarePlus products offered by such association and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization.

''(f) HIGH DEDUCTIBLE/MEDISAVE PRODUCT DEFINED.—

''(1) IN GENERAL.—In this part, the term 'high deductible/medisave product' means a MedicarePlus product that—

''(A) provides reimbursement for at least the items and services described in section 1852(a)(1) in a year but only after the enrollee incurs countable expenses (as specified under the product) equal to the amount of a deductible (described in paragraph (2));

''(B) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B or by the enrollee if the enrollee had elected to receive benefits through the provisions of such parts; and

''(C) provides, after such deductible is met for a year and for all subsequent expenses for benefits referred to in subparagraph (A) in the year, for a level of reimbursement that is not less than—

''(i) 100 percent of such expenses, or

''(ii) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less. Such term does not include the MedicarePlus MSA itself or any contribution into such account.

''(2) DEDUCTIBLE.—The amount of deductible under a high deductible/medisave product—

''(A) for contract year 1997 shall be not more than $10,000; and

''(B) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this paragraph increased by the national average per capita growth rate under section 1855(c)(3) for the year.

If the amount of the deductible under subparagraph (B) is not a multiple of $50, the amount shall be rounded to the nearest multiple of $50.

''(g) ORGANIZATIONS TREATED AS MEDICAREPLUS ORGANIZATIONS DURING TRANSITION.—Any of the following organizations shall be considered to qualify as a MedicarePlus organization for contract years beginning before January 1, 1998:

''(1) HEALTH MAINTENANCE ORGANIZATIONS.—An organization that is organized under the laws of any State and that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act), an organization recognized under State law as a health maintenance organization, or a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

''(2) LICENSED INSURERS.—An organization that is organized under the laws of any State and—

''(A) is licensed by a State agency as an insurer for the offering of health benefit coverage, or

''(B) is licensed by a State agency as a service benefit plan,

but only for individuals residing in an area in which the organization is licensed to offer health insurance coverage.

''(3) CURRENT RISK-CONTRACTORS.—An organization that is an eligible organization (as defined in section 1876(b)) and that has a risk-sharing contract in effect under section 1876 as of the date of the enactment of this section.

''(h) MEDIGRANT DEMONSTRATION PROJECTS.—The Secretary shall provide, in at least 10 States, for demonstration projects which would permit MediGrant programs under title XXI to be treated as MedicarePlus organizations under this part for individuals who are qualified to elect the MedicarePlus option and who eligible to receive medical assistance under the MediGrant program, for the purpose of demonstrating the delivery of primary, acute, and long-term care through an integrated delivery network which emphasizes noninstitutional care.

''REQUIREMENTS RELATING TO BENEFITS, PROVISION OF SERVICES, ENROLLMENT, AND PREMIUMS

''SEC. 1852. (a) BENEFITS COVERED.—

''(1) IN GENERAL.—Except as provided in section 1851(f)(1) with respect to high deductible/medisave products, each MedicarePlus product offered under this part shall provide benefits for at least the items and services for which benefits are available under parts A and B consistent with the standards for coverage of such items and services applicable under this title.

''(2) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicarePlus organization may (in the case of the provision of items and services to an individual under this part under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

''(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

''(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

''(3) SATISFACTION OF REQUIREMENT.—A MedicarePlus product (other than a high deductible/medisave product) offered by a MedicarePlus organization satisfies paragraph (1) with respect to benefits for items and services if the following requirements are met:

''(A) FEE FOR SERVICE PROVIDERS.—In the case of benefits furnished through a provider that does not have a contract with the organization, the product provides for at least the dollar amount of payment for such items and services as would otherwise be provided under parts A and B.

''(B) PARTICIPATING PROVIDERS.—In the case of benefits furnished through a provider that has such a contract, the individual's liability for payment for such items and services does not exceed (after taking into account any deductible, which does not exceed any deductible under parts A and B) the lesser of the following:

''(i) NON-MEDICAREPLUS LIABILITY.—The amount of the liability that the individual would have had (based on the provider being a participating provider) if the individual had elected the non-MedicarePlus option.

''(ii) MEDICARE COINSURANCE APPLIED TO PRODUCT PAYMENT RATES.—The applicable coinsurance or copayment rate (that would have applied under the non-MedicarePlus option) of the payment rate provided under the contract.

''(b) ANTIDISCRIMINATION.—A MedicarePlus organization may not deny, limit, or condition the coverage or provision of benefits under this part based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

''(c) GUARANTEED ISSUE AND RENEWAL.—

''(1) IN GENERAL.—Except as provided in this subsection, a MedicarePlus organization shall provide that at any time during which elections are accepted under section 1805 with respect to a MedicarePlus product offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

''(2) PRIORITY.—If the Secretary determines that a MedicarePlus organization, in relation to a MedicarePlus product it offers, has a capacity limit and the number of eligible individuals who elect the product under section 1805 exceeds the capacity limit, the organization may limit the election of individuals of the product under such section but only if priority in election is provided—

''(A) first to such individuals as have elected the product at the time of the determination, and

''(B) then to other such individuals in such a manner that does not discriminate among the individuals (who seek to elect the product) on a basis described in subsection (b).

''(3) LIMITATION ON TERMINATION OF ELECTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), a MedicarePlus organization may not for any reason terminate the election of any individual under section 1805 for a MedicarePlus product it offers.

''(B) BASIS FOR TERMINATION OF ELECTION.—A MedicarePlus organization may terminate an individual's election under section 1805 with respect to a MedicarePlus product it offers if—

''(i) any premiums required with respect to such product are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of premiums),

''(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

''(iii) the product is terminated with respect to all individuals under this part.

Any individual whose election is so terminated is deemed to have elected the Non-MedicarePlus option (as defined in section 1805(a)(3)(A)).

''(C) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1858, each MedicarePlus organization receiving an election form under section 1805(c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

''(4) SPECIAL RULES FOR LIMITED ENROLLMENT MEDICAREPLUS ORGANIZATIONS.—

''(A) UNIONS.—

''(i) IN GENERAL.—Subject to subparagraph (D), a union sponsor (as defined in clause (ii)) shall limit eligibility of enrollees under this part for MedicarePlus products it offers to individuals who are members of the sponsor and affiliated with the sponsor through an employment relationship with any employer or are the spouses of such members.

''(ii) UNION SPONSOR.—In this part and section 1805, the term 'union sponsor' means an employee organization in relation to a group health plan that is established or maintained by the organization other than pursuant to a collective bargaining agreement.

''(B) TAFT-HARTLEY SPONSORS.—

''(i) IN GENERAL.—Subject to subparagraph (D), a MedicarePlus organization that is a Taft-Hartley sponsor (as defined in clause (ii)) shall limit eligibility of enrollees under this part for MedicarePlus products it offers to individuals who are entitled to obtain benefits through such products under the terms of an applicable collective bargaining agreement.

''(ii) TAFT-HARTLEY SPONSOR.—In this part and section 1805, the term 'Taft-Hartley sponsor' means, in relation to a group health plan that is established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of parties who establish or maintain the plan.

''(C) QUALIFIED ASSOCIATIONS.—

''(i) IN GENERAL.—Subject to subparagraph (D), a MedicarePlus organization that is a qualified association (as defined in clause (iii)) shall limit eligibility of individuals under this part for products it offers to individuals who are members of the association (or who are spouses of such individuals).

''(ii) LIMITATION ON TERMINATION OF COVERAGE.—Such a qualifying association offering a MedicarePlus product to an individual may not terminate coverage of the individual on the basis that the individual is no longer a member of the association except pursuant to a change of election during an open election period occurring on or after the date of the termination of membership.

''(iii) QUALIFIED ASSOCIATION.—In this part and section 1805, the term 'qualified association' means an association, religious fraternal organization, or other organization (which may be a trade, industry, or professional association, a chamber of commerce, or a public entity association) that the Secretary finds—

''(I) has been formed for purposes other than the sale of any health insurance and does not restrict membership based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual,

''(II) does not exist solely or principally for the purpose of selling insurance, and

''(III) has at least 1,000 individual members or 200 employer members.

Such term includes a subsidiary or corporation that is wholly owned by one or more qualified organizations.

''(D) LIMITATION.—Rules of eligibility to carry out the previous subparagraphs of this paragraph shall not have the effect of denying eligibility to individuals on the basis of health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability.

''(E) LIMITED ENROLLMENT MEDICAREPLUS ORGANIZATION.—In this part and section 1805, the term 'limited enrollment MedicarePlus organization' means a MedicarePlus organization that is a union sponsor, a Taft-Hartley sponsor, or a qualified association.

''(F) EMPLOYER, ETC..—In this paragraph, the terms 'employer', 'employee organization', and 'group health plan' have the meanings given such terms for purposes of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(d) SUBMISSION AND CHARGING OF PREMIUMS.—

''(1) IN GENERAL.—Each MedicarePlus organization shall file with the Secretary each year, in a form and manner and at a time specified by the Secretary—

''(A) the amount of the monthly premiums for coverage under each MedicarePlus product it offers under this part in each payment area (as determined for purposes of section 1855) in which the product is being offered; and

''(B) the enrollment capacity in relation to the product in each such area.

''(2) AMOUNTS OF PREMIUMS CHARGED.—The amount of the monthly premium charged by a MedicarePlus organization for a MedicarePlus product offered in a payment area to an individual under this part shall be equal to the amount (if any) by which—

''(A) the amount of the monthly premium for the product for the period involved, as established under paragraph (3) and submitted under paragraph (1), exceeds

''(B)(i) 1/12 of the annual MedicarePlus capitation rate specified in section 1855(b)(2) for the area and period involved, or (ii) in the case of a high deductible/medisave product, the monthly adjusted MedicarePlus capitation rate specified in section 1855(b)(1) for the individual and period involved.

''(3) UNIFORM PREMIUM.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the premiums charged by a MedicarePlus organization under this part may not vary among individuals who reside in the same payment area.

''(B) EXCEPTION FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCTS.—A MedicarePlus organization shall establish premiums for any high deductible/medisave product it offers in a payment area based on each of the risk adjustment categories established for purposes of determining the amount of the payment to MedicarePlus organizations under section 1855(b)(1) and using the identical demographic and other adjustments among such categories as are used for such purposes.

''(4) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each MedicarePlus organization shall permit the payment of monthly premiums on a monthly basis and may terminate election of individuals for a MedicarePlus product for failure to make premium payments only in accordance with subsection (c)(3)(B).

''(5) RELATION OF PREMIUMS AND COST-SHARING TO BENEFITS.—In no case may the portion of a MedicarePlus organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (to the extent attributable to the minimum benefits described in subsection (a)(1) and not counting any amount attributable to balance billing) to individuals who are enrolled under this part with the organization exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this part with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this part with the organization, or other appropriate data) and entitled to benefits under part A and enrolled under part B if they were not members of a MedicarePlus organization.

''(e) REQUIREMENT FOR ADDITIONAL BENEFITS, PART B PREMIUM DISCOUNT REBATES, OR BOTH.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—Each MedicarePlus organization (in relation to a MedicarePlus product it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the product for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify), a monetary rebate (paid on a monthly basis) of the part B monthly premium, or a combination thereof, in an total value which is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

''(B) EXCESS AMOUNT.—For purposes of this paragraph, the 'excess amount', for an organization for a product, is the amount (if any) by which—

''(i) the average of the capitation payments made to the organization under this part for the product at the beginning of contract year, exceeds

''(ii) the actuarial value of the minimum benefits described in subsection (a)(1) under the product for individuals under this part, as determined based upon an adjusted community rate described in paragraph (5) (as reduced for the actuarial value of the coinsurance and deductibles under parts A and B).

''(C) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the 'adjusted excess amount', for an organization for a product, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (3).

''(D) NO APPLICATION TO HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—Subparagraph (A) shall not apply to a high deductible/medisave product.

''(E) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a product in a service area.

''(F) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a MedicarePlus organization from providing health care benefits that are in addition to the benefits otherwise required to be provided under this paragraph and from imposing a premium for such additional benefits.

''(2) LIMITATION ON AMOUNT OF PART B PREMIUM DISCOUNT REBATE.—In no case shall the amount of a part B premium discount rebate under paragraph (1)(A) exceed, with respect to a month, the amount of premiums imposed under part B (not taking into account section 1839(b) (relating to penalty for late enrollment) or 1839(h) (relating to affluence testing)), for the individual for the month. Except as provided in the previous sentence, a MedicarePlus organization is not authorized to provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

''(3) STABILIZATION FUND.—A MedicarePlus organization may provide that a part of the value of an excess actuarial amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits and rebates offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the MedicarePlus product in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

''(4) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience (including no enrollment experience in the case of a provider-sponsored organization) to determine an average of the capitation payments to be made under this part at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part.

''(5) ADJUSTED COMMUNITY RATE.—

''(A) IN GENERAL.—For purposes of this subsection, subject to subparagraph (B), the term 'adjusted community rate' for a service or services means, at the election of a MedicarePlus organization, either—

''(i) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicarePlus product under this part if the rate of payment were determined under a 'community rating system' (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

''(ii) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the

differences between the utilization characteristics of individuals selecting other MedicarePlus coverage, or individuals in the area, in the State, or in the United States, eligible to elect MedicarePlus coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

''(B) SPECIAL RULE FOR PROVIDER-SPONSORED ORGANIZATIONS.—In the case of a MedicarePlus organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a MedicarePlus product may be computed (in a manner specified by the Secretary) using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a product.

''(f) RULES REGARDING PHYSICIAN PARTICIPATION.—

''(1) PROCEDURES.—Each MedicarePlus organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under MedicarePlus products offered by the organization under this part. Such procedures shall include—

''(A) providing notice of the rules regarding participation,

''(B) providing written notice of participation decisions that are adverse to physicians, and

''(C) providing a process within the organization for appealing adverse decisions, including the presentation of information and views of the physician regarding such decision.

''(2) CONSULTATION IN MEDICAL POLICIES.—A MedicarePlus organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

''(3) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

''(A) IN GENERAL.—Each MedicarePlus organization may not operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

''(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

''(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

''(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

''(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

''(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

''(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term 'physician incentive plan' means any compensation arrangement between a MedicarePlus organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

''(4) LIMITATION ON PROVIDER INDEMNIFICATION.—A MedicarePlus organization may not provide (directly or indirectly) for a provider (or group of providers) to indemnify the organization against any liability resulting from a civil action brought by or on behalf of an enrollee under this part for any damage caused to the enrollee by the organization's denial of medically necessary care.

''(5) EXCEPTION FOR CERTAIN FEE-FOR-SERVICE PLANS.—The previous provisions of this subsection shall not apply in the case of a MedicarePlus organization in relation to a MedicarePlus product if the organization does not have agreements between physicians and the organization for the provision of benefits under the product.

''(g) PROVISION OF INFORMATION.—A MedicarePlus organization shall provide the Secretary with such information on the organization and each MedicarePlus product it offers as may be required for the preparation of the information booklet described in section 1805(d)(3)(A).

''(h) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICAREPLUS PRODUCT.—Nothing in this part shall be construed as preventing a State from coordinating benefits under its MediGrant program under title XXI with those provided under a MedicarePlus product in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such program.

''(i) TRANSITIONAL FILE AND USE FOR CERTAIN REQUIREMENTS.—

''(1) IN GENERAL.—In the case of a MedicarePlus product proposed to be offered before the end of the transition period (as defined in section 1805(e)(1)(B)), by a MedicarePlus organization described in section 1851(g)(3) or by a MedicarePlus organization with a contract in effect under section 1858, if the organization submits complete information to the Secretary regarding the product demonstrating that the product meets the requirements and standards under subsections (a), (d), and (e) (relating to benefits and premiums), the product shall be deemed as meeting such requirements and standards under such subsections unless the Secretary disapproves the product within 60 days after the date of submission of the complete information.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as waiving the requirement of a contract under section 1858 or waiving requirements and standards not referred to in paragraph (1).

''PATIENT PROTECTION STANDARDS

''SEC. 1853. (a) DISCLOSURE TO ENROLLEES.—A MedicarePlus organization shall disclose in clear, accurate, and standardized form, information regarding all of the following for each MedicarePlus product it offers:

''(1) Benefits under the MedicarePlus product offered, including exclusions from coverage and, if it is a high deductible/medisave product, a comparison of benefits under such a product with benefits under other MedicarePlus products.

''(2) Rules regarding prior authorization or other review requirements that could result in nonpayment.

''(3) Potential liability for cost-sharing for out-of-network services.

''(4) The number, mix, and distribution of participating providers.

''(5) The financial obligations of the enrollee, including premiums, deductibles, copayments, and maximum limits on out-of-pocket losses for items and services (both in and out of network).

''(6) Statistics on enrollee satisfaction with the product and organization, including rates of reenrollment.

''(7) Enrollee rights and responsibilities, including the grievance process provided under subsection (f).

''(8) A statement that the use of the 911 emergency telephone number is appropriate in emergency situations and an explanation of what constitutes an emergency situation.

''(9) A description of the organization's quality assurance program under subsection (d).

Such information shall be disclosed to each enrollee under this part at the time of enrollment and at least annually thereafter.

''(b) ACCESS TO SERVICES.—

''(1) IN GENERAL.—A MedicarePlus organization offering a MedicarePlus product may restrict the providers from whom the benefits under the product are provided so long as—

''(A) the organization makes such benefits available and accessible to each individual electing the product within the product service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

''(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

''(C) the product provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

''(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and

''(ii) it was not reasonable given the circumstances to obtain the services through the organization; and

''(D) coverage is provided for emergency services (as defined in paragraph (4)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

''(2) MINIMUM PAYMENT LEVELS WHERE PROVIDING POINT-OF-SERVICE COVERAGE.—If a MedicarePlus product provides benefits for items and services (not described in paragraph (1)(C)) through a network of providers and also permits payment to be made under the product for such items and services not provided through such a network, the payment level under the product with respect to such items and services furnished outside the network shall be at least 70 percent (or, if the effective cost-sharing rate is 50 percent, at least 40 percent) of the lesser of—

''(A) the payment basis (determined without regard to deductibles and cost-sharing) that would have applied for such items and services under parts A and B, or

''(B) the amount charged by the entity furnishing such items and services.

''(3) PROTECTION OF ENROLLEES FOR CERTAIN EMERGENCY SERVICES.—

''(A) PARTICIPATING PROVIDERS.—In the case of emergency services described in subparagraph (C) which are furnished by a participating physician or provider of services to an individual enrolled with a MedicarePlus organization under this section, the applicable participation agreement is deemed to provide that the physician or provider of services will accept as payment in full from the organization for such emergency services described in subparagraph (C) the amount that would be payable to the

physician or provider of services under part B and from the individual under such part, if the individual were not enrolled with such an organization under this part.

''(B) NONPARTICIPATING PROVIDERS.—In the case of emergency services described in subparagraph (C) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with a MedicarePlus organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

''(C) EMERGENCY SERVICES DESCRIBED.—The emergency services described in this subparagraph are emergency services which which are furnished to an enrollee of a MedicarePlus organization under this part by a physician or provider of services that is not under a contract with the organization.

''(D) EXCEPTION FOR CERTAIN FEE-FOR-SERVICE PLANS.—The previous provisions of this paragraph shall not apply in the case of a MedicarePlus organization in relation to a MedicarePlus product if the organization does not have agreements between physicians and the organization for the provision of benefits under the product.

''(4) DEFINITION OF EMERGENCY SERVICES.—In this subsection, the term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

''(A) are furnished by an appropriate source other than the organization,

''(B) are needed immediately because of an injury or sudden illness, and

''(C) are needed because the time required to reach the organization's providers or suppliers would have meant risk of serious damage to the patient's health.

''(c) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each MedicarePlus organization shall establish procedures—

''(1) to safeguard the privacy of individually identifiable enrollee information, and

''(2) to maintain accurate and timely medical records for enrollees.

''(d) QUALITY ASSURANCE PROGRAM.—

''(1) IN GENERAL.—Each MedicarePlus organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals.

''(2) ELEMENTS OF PROGRAM.—The quality assurance program shall—

''(A) stress health outcomes;

''(B) provide for the establishment of written protocols for utilization review, based on current standards of medical practice;

''(C) provide review by physicians and other health care professionals of the process followed in the provision of such health care services;

''(D) monitors and evaluates high volume and high risk services and the care of acute and chronic conditions;

''(E) evaluates the continuity and coordination of care that enrollees receive;

''(F) has mechanisms to detect both underutilization and overutilization of services;

''(G) after identifying areas for improvement, establishes or alters practice parameters;

''(H) takes action to improve quality and assesses the effectiveness of such action through systematic follow-up;

''(I) makes available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate);

''(J) is evaluated on an ongoing basis as to its effectiveness; and

''(K) provide for external accreditation or review, by a utilization and quality control peer review organization under part B of title XI or other qualified independent review organization, of the quality of services furnished by the organization meets professionally recognized standards of health care (including providing adequate access of enrollees to services).

''(3) EXCEPTION FOR CERTAIN FEE-FOR-SERVICE PLANS.—Paragraph (1) and subsection (c)(2) shall not apply in the case of a MedicarePlus organization in relation to a MedicarePlus product to the extent the organization provides for coverage of benefits without restrictions relating to utilization and without regard to whether the provider has a contract or other arrangement with the plan for the provision of such benefits.

''(4) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a MedicarePlus organization is deemed to meet the requirements of paragraphs (1) and (2) of this subsection and subsection (c) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization meets standards that are no less stringent than the standards established under section 1856 to carry out this subsection and subsection (c).

''(e) COVERAGE DETERMINATIONS.—

''(1) DECISIONS ON NONEMERGENCY CARE.—A MedicarePlus organization shall make determinations regarding authorization requests for nonemergency care on a timely basis, depending on the urgency of the situation.

''(2) APPEALS.—

''(A) IN GENERAL.—Appeals from a determination of an organization denying coverage shall be decided within 30 days of the date of receipt of medical information, but not later than 60 days after the date of the decision.

''(B) PHYSICIAN DECISION ON CERTAIN APPEALS.—Appeal decisions relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician.

''(C) EMERGENCY CASES.—Appeals from such a determination involving a life-threatening or emergency situation shall be decided on an expedited basis.

''(f) GRIEVANCES AND APPEALS.—

''(1) GRIEVANCE MECHANISM.—Each MedicarePlus organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees under this part.

''(2) APPEALS.—An enrollee with an organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying sections 205(b) and 205(g) as provided in this subparagraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

''(3) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve appeals of denials of coverage related to urgent or emergency services with respect to MedicarePlus products.

''(4) COORDINATION WITH SECRETARY OF LABOR.—The Secretary shall consult with the Secretary of Labor so as to ensure that the requirements of this subsection, as they apply in the case of grievances referred to in paragraph (1) to which section 503 of the Employee Retirement Income Security Act of 1974 applies, are applied in a manner consistent with the requirements of such section 503.

''(g) INFORMATION ON ADVANCE DIRECTIVES.—Each MedicarePlus organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

''(h) APPROVAL OF MARKETING MATERIALS.—

''(1) SUBMISSION.—Each MedicarePlus organization may not distribute marketing materials unless—

''(A) at least 45 days before the date of distribution the organization has submitted the material to the Secretary for review, and

''(B) the Secretary has not disapproved the distribution of such material.

''(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of all such material submitted and under such guidelines the Secretary shall disapprove such material if the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

''(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing materials under paragraph (1)(B) with respect to a MedicarePlus product in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the product and organization.

''(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each MedicarePlus organization shall conform to fair marketing standards in relation to MedicarePlus products offered under this part, included in the standards established under section 1856. Such standards shall include a prohibition against an organization (or agent of such an organization) completing any portion of any election form under section 1805 on behalf of any individual.

''PROVIDER-SPONSORED ORGANIZATIONS

''SEC. 1854. (a) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

''(1) IN GENERAL.—In this part, the term 'provider-sponsored organization' means a public or private entity that (in accordance with standards established under subsection (b)) is a provider, or group of affiliated providers, that provides a substantial proportion (as defined by the Secretary under such standards) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers.

''(2) SUBSTANTIAL PROPORTION.—In defining what is a 'substantial proportion' for purposes of paragraph (1), the Secretary—

''(A) shall take into account the need for such an organization to assume responsibility for a substantial proportion of services in order to assure financial stability and the practical difficulties in such an organization integrating a very wide range of service providers; and

''(B) may vary such proportion based upon relevant differences among organizations, such as their location in an urban or rural area.

''(3) AFFILIATION.—For purposes of this subsection, a provider is 'affiliated' with another provider if, through contract, ownership, or otherwise—

''(A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,

''(B) each provider is a participant in a lawful combination under which each provider shares, directly or indirectly, substantial financial risk in connection with their operations,

''(C) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986, or

''(D) both providers are part of an affiliated service group under section 414 of such Code.

''(4) CONTROL.—For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

''(b) PROCESS FOR ESTABLISHING STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—For process of establishing of standards for provider-sponsored organizations, see section 1856(c).

''(c) PROCESS FOR STATE CERTIFICATION OF PROVIDER-SPONSORED ORGANIZATIONS.—For process of State certification of provider-sponsored organizations, see section 1857(c).

''(d) PREEMPTION OF STATE INSURANCE LICENSING REQUIREMENTS.—

''(1) IN GENERAL.—This section supersedes any State law which—

''(A) requires that a provider-sponsored organization meet requirements for insurers of health services or health maintenance organizations doing business in the State with respect to initial capitalization and establishment of financial reserves against insolvency, or

''(B) imposes requirements that would have the effect of prohibiting the organization from complying with the applicable requirements of this part,

insofar as such the law applies to individuals enrolled with the organization under this part.

''(2) EXCEPTION.—Paragraph (1) shall not apply with respect to any State law to the extent that such law provides standards or requirements, or provides for enforcement thereof, so as to meet the requirements of section 1857(c)(2) with respect to approval by the Secretary of State certification requirements thereunder.

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the operation of section 514 of the Employee Retirement Income Security Act of 1974.

''PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

''SEC. 1855. (a) PAYMENTS.—

''(1) IN GENERAL.—Under a contract under section 1858 the Secretary shall pay to each MedicarePlus organization, with respect to coverage of an individual under this part in a payment area for a month, an amount equal to the monthly adjusted MedicarePlus capitation rate (as provided under subsection (b)) with respect to that individual for that area.

''(2) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned—

''(A) the annual MedicarePlus capitation rate for each payment area for the year, and

''(B) the factors to be used in adjusting such rates under subsection (b) for payments for months in that year.

''(3) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (2) for a year, the Secretary shall provide for notice to MedicarePlus organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

''(4) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (2) for a year, the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that MedicarePlus organizations can compute monthly adjusted MedicarePlus capitation rates for classes of individuals located in each payment area which is in whole or in part within the service area of such an organization.

''(b) MONTHLY ADJUSTED MEDICAREPLUS CAPITATION RATE.—

''(1) IN GENERAL.—For purposes of this section, the 'monthly adjusted MedicarePlus capitation rate' under this subsection, for a month in a year for an individual in a payment area (specified under paragraph (3)) and in a class (established under paragraph (4)), is 1/12 of the annual MedicarePlus capitation rate specified in paragraph (2) for that area for the year, adjusted to reflect the actuarial value of benefits under this title with respect to individuals in such class compared to the national average for individuals in all classes.

''(2) ANNUAL MEDICAREPLUS CAPITATION RATES.—For purposes of this section, the annual MedicarePlus capitation rate for a payment area for a year is equal to the annual MedicarePlus capitation rate for the area for the previous year (or, in the case of 1996, the average annual per capita rate of payment described in section 1876(a)(1)(C) for the area for 1995) increased by the per capita growth rate for that area and year (as determined under subsection (c)).

''(3) PAYMENT AREA DEFINED.—In this section, the term 'payment area' means a county (or equivalent area specified by the Secretary), except that in the case of the population group described in paragraph (5)(C), the payment area shall be each State.

''(4) CLASSES.—

''(A) IN GENERAL.—For purposes of this section, the Secretary shall define appropriate classes of enrollees, consistent with paragraph (5), based on age, gender, welfare status, institutionalization, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

''(B) RESEARCH.—The Secretary shall conduct such research as may be necessary to provide for greater accuracy in the adjustment of capitation rates under this subsection. Such research may include research into the addition or modification of classes under subparagraph (A). The Secretary shall submit to Congress a report on such research by not later than January 1, 1997.

''(5) DIVISION OF MEDICARE POPULATION.—In carrying out paragraph (4) and this section, the Secretary shall recognize the following separate population groups:

''(A) AGED.—Individuals 65 years of age or older who are not described in subparagraph (C).

''(B) DISABLED.—Disabled individuals who are under 65 years of age and not described in subparagraph (C).

''(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—Individuals who are determined to have end stage renal disease.

''(c) PER CAPITA GROWTH RATES.—

''(1) FOR 1996.—

''(A) IN GENERAL.—For purposes of this section and subject to subparagraph (B), the per capita growth rates for 1996, for a payment area assigned to a service utilization cohort under subsection (d), shall be the following:

''(i) LOWEST SERVICE UTILIZATION COHORT.—For areas assigned to the lowest service utilization cohort, 9.7 percent plus the additional percent provided under subparagraph (B)(ii).

''(ii) LOWER SERVICE UTILIZATION COHORT.—For areas assigned to the lower service utilization cohort, 8.0 percent.

''(iii) MEDIAN SERVICE UTILIZATION COHORT.—For areas assigned to the median service utilization cohort, 5.1 percent.

''(iv) HIGHER SERVICE UTILIZATION COHORT.—For areas assigned to the higher service utilization cohort, 4.7 percent.

''(v) HIGHEST SERVICE UTILIZATION COHORT.—For areas assigned to the highest service utilization cohort, 4.0 percent.

''(B) BUDGET NEUTRAL ADJUSTMENT.—In order to assure that the total capitation payments under this section during 1996 are the same as the amount such payments would have been if the per capita growth rate for all such areas for 1996 were equal to the national average per capita growth rate, specified in paragraph (3) for 1996, the Secretary shall adjust the per capita growth rates for payment areas as follows:

''(i) INCREASE UP TO FLOOR FOR LOWEST SERVICE UTILIZATION COHORT.—First, such additional percent increase as may be necessary to assure that the annual MedicarePlus capitation rate for each payment area is at least 12 times $250 for 1996.

''(ii) RESIDUAL INCREASE TO LOWEST SERVICE UTILIZATION COHORT.—Next, for payment areas assigned to the lowest service utilization cohort, such additional percent increase as will assure that the total capitation payments under this section during 1996 are the same as the amount such payments would have been if the per capita growth rate for all such areas for 1996 were equal to the national average per capita growth rate. The increase under this clause may apply to a payment area described in clause (i) and shall be applied after the increase provided under such clause.

''(2) FOR SUBSEQUENT YEARS.—

''(A) IN GENERAL.—For purposes of this section and subject to subparagraph (B), the Secretary shall compute a per capita growth rate for each year after 1996, for each payment area as assigned to a service utilization cohort under subsection (d), consistent with the following rules:

''(i) MEDIAN SERVICE UTILIZATION COHORT SET AT NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the median service utilization cohort for the year shall be the national average per capita growth rate for the year (as specified under paragraph (3)), subject to subparagraph (C).

''(ii) HIGHEST SERVICE UTILIZATION COHORT SET AT 75 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the highest service utilization cohort for the year shall be 75 percent of the national average per capita growth rate for the year.

''(iii) LOWEST SERVICE UTILIZATION COHORT SET AT 187.5 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the lowest service utilization cohort for the year shall be 187.5 percent of the national average per capita growth rate for the year, subject to subparagraph (C).

''(iv) LOWER SERVICE UTILIZATION COHORT SET AT 150 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—

''(I) IN GENERAL.—Subject to subclause (II), the per capita growth rate for areas assigned to the lower service utilization cohort for the year shall be 150 percent of the national average per capita growth rate for the year.

''(II) ADJUSTMENT.—If the Secretary has established under clause (v) the per capita growth rate for areas assigned to the higher service utilization cohort for the year at 75 percent of the national average per capita growth rate, the Secretary may provide for a reduced per capita growth rate under subclause (I) to the extent necessary to comply with subparagraph (B).

''(v) HIGHER SERVICE UTILIZATION COHORT.—The per capita growth rate for areas assigned to the higher service utilization cohort for the year shall be such percent (not less than 75 percent) of the national average per capita growth rate, as the Secretary may determine consistent with subparagraph (B).

''(B) AVERAGE PER CAPITA GROWTH RATE AT NATIONAL AVERAGE TO ASSURE BUDGET NEUTRALITY.—The Secretary shall compute per capita growth rates for a year under subparagraph (A) (before the application of subparagraph (C)) in a manner so that the weighted average per capita growth rate for all areas for the year (weighted to reflect the number of medicare beneficiaries in each area) is equal to the national average per capita growth rate under paragraph (3) for the year.

''(C) FINAL ADJUSTMENT OF GROWTH RATES.—After computing per capita growth rates under the previous provisions of this paragraph the Secretary shall—

''(i) reduce the per capita growth rate for areas assigned to the median service utilization cohort by the ratio of .1 to 5.3, and

''(ii) increase the per capita growth rate for areas assigned to the lowest service utilization cohort by such proportion as the Secretary determines will result in an increase in outlays resulting from this clause equal to the reduction in outlays resulting from clause (i) for the year involved.

''(3) NATIONAL AVERAGE PER CAPITA GROWTH RATES.—In this subsection, the 'national average per capita growth rate' for—

''(A) 1996 is 5.3 percent,

''(B) 1997 is 3.8 percent,

''(C) 1998 is 4.6 percent,

''(D) 1999 is 4.3 percent,

''(E) 2000 is 3.8 percent,

''(F) 2001 is 5.5 percent,

''(G) 2002 is 5.6 percent, and

''(H) each subsequent year is 5.0 percent.

''(d) ASSIGNMENT OF PAYMENT AREAS TO SERVICE UTILIZATION COHORTS.—

''(1) IN GENERAL.—For purposes of determining per capita growth rates under subsection (c) for areas for a year, the Secretary shall assign each payment area to a service utilization cohort (based on the service utilization index value for that area determined under paragraph (2)) as follows:

''(A) LOWEST SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of less than .80 shall be assigned to the lowest service utilization cohort.

''(B) LOWER SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least .80 but less than .90 shall be assigned to the lower service utilization cohort.

''(C) MEDIAN SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least .90 but less than 1.10 shall be assigned to the median service utilization cohort.

''(D) HIGHER SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least 1.10 but less than 1.20 shall be assigned to the higher service utilization cohort.

''(E) HIGHEST SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least 1.20 shall be assigned to the highest service utilization cohort.

''(2) DETERMINATION OF SERVICE UTILIZATION INDEX VALUES.—In order to determine the per capita growth rate for a payment area for each year (beginning with 1996), the Secretary shall determine for such area and year a service utilization index value, which is equal to—

''(A) the annual MedicarePlus capitation rate under this section for the area for the year in which the determination is made (or, in the case of 1996, the average annual per capita rate of payment (described in section 1876(a)(1)(C)) for the area for 1995); divided by

''(B) the input-price-adjusted annual national MedicarePlus capitation rate (as determined under paragraph (3)) for that area for the year in which the determination is made.

''(3) DETERMINATION OF INPUT-PRICE-ADJUSTED RATES.—

''(A) IN GENERAL.—For purposes of paragraph (2), the 'input-price-adjusted annual national MedicarePlus capitation rate' for a payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type) of—

''(i) the national standardized MedicarePlus capitation rate (determined under subparagraph (B)) for the year,

''(ii) the proportion of such rate for the year which is attributable to such type of services, and

''(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary shall, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

''(B) NATIONAL STANDARDIZED MEDICAREPLUS CAPITATION RATE.—In this paragraph, the 'national standardized MedicarePlus capitation rate' for a year is equal to—

''(i) the sum (for all payment areas) of the product of (I) the annual MedicarePlus capitation rate for that year for the area under subsection (b)(2), and (II) the average number of medicare beneficiaries residing in that area in the year; divided by

''(ii) the total average number of medicare beneficiaries residing in all the payment areas for that year.

''(C) SPECIAL RULES FOR 1996.—In applying this paragraph for 1996—

''(i) medicare services shall be divided into 2 types of services: part A services and part B services;

''(ii) the proportions described in subparagraph (A)(ii) for such types of services shall be—

''(I) for part A services, the ratio (expressed as a percentage) of the average annual per capita rate of payment for the area for part A for 1995 to the total average annual per capita rate of payment for the area for parts A and B for 1995, and

''(II) for part B services, 100 percent minus the ratio described in subclause (I);

''(iii) for the part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1886(d)(3)(E) to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

''(iv) for part B services—

''(I) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1848(e) used to adjust payment rates for physicians' services furnished in the payment area, and

''(II) of the remaining 34 percent of the amount of such payments, 70 percent shall be adjusted by the index described in clause (iii);

''(v) the index values shall be computed based only on the beneficiary population described in subsection (b)(5)(A).

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1997.

''(e) PAYMENT PROCESS.—

''(1) IN GENERAL.—Subject to subsection (f), the Secretary shall make monthly payments under this section in advance and in accordance with the rate determined under subsection (a) to the plan for each individual enrolled with a MedicarePlus organization under this part.

''(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

''(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

''(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a MedicarePlus organization under a product operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

''(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1853(a) at the time the individual enrolled with the organization.

''(f) SPECIAL RULES FOR INDIVIDUALS ELECTING HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—

''(1) IN GENERAL.—In the case of an individual who has elected a high deductible/medisave product, notwithstanding the preceding provisions of this section—

''(A) the amount of the payment to the MedicarePlus organization offering the high deductible/medisave product shall not exceed the premium for the product, and

''(B) subject to paragraph (2), the difference between the amount of payment that would otherwise be made and the amount of payment to such organization shall be made directly into a MedicarePlus MSA established (and, if applicable, designated) by the individual under paragraph (2).

''(2) ESTABLISHMENT AND DESIGNATION OF MEDICAREPLUS MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under a high deductible/medisave product, no payment shall be made under paragraph (1)(B) on behalf of an individual for a month unless the individual—

''(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a MedicarePlus MSA (as defined in section 137(b) of the Internal Revenue Code of 1986), and

''(B) if the individual has established more than one MedicarePlus MSA, has designated

one of such accounts as the individual's MedicarePlus MSA for purposes of this part. Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

''(3) LUMP SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing a high deductible/medisave product effective beginning with a month in a year, the amount of the contribution to the MedicarePlus MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

''(g) PAYMENTS FROM TRUST FUND.—The payment to a MedicarePlus organization under this section for individuals enrolled under this part with the organization, and payments to a MedicarePlus MSA under subsection (f)(1)(B), shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title.

''(h) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

''(1) election under this part of a MedicarePlus product offered by a MedicarePlus organization—

''(A) payment for such services until the date of the individual's discharge shall be made under this title through the MedicarePlus product or Non-MedicarePlus option (as the case may be) elected before the election with such organization,

''(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

''(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

''(2) termination of election with respect to a MedicarePlus organization under this part—

''(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

''(B) payment for such services during the stay shall not be made under section 1886(d) or by any succeeding MedicarePlus organization, and

''(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

''ESTABLISHMENT OF STANDARDS FOR MEDICARE-PLUS ORGANIZATIONS AND PRODUCTS

''SEC. 1856. (a) STANDARDS APPLICABLE TO STATE-REGULATED ORGANIZATIONS AND PRODUCTS.—

''(1) RECOMMENDATIONS OF NAIC.—The Secretary shall request the National Association of Insurance Commissioners to develop and submit to the Secretary, not later than 12 months after the date of the enactment of the Medicare Preservation Act of 1995, proposed standards consistent with the requirements of this part for MedicarePlus organizations (other than union sponsors, Taft-Hartley sponsors, and provider-sponsored organizations) and MedicarePlus products offered by such organizations, except that such proposed standards may relate to MedicarePlus organizations that are qualified associations only with respect to MedicarePlus products offered by them and only if such products are issued by organizations to which section 1851(b)(1) applies.

''(2) REVIEW.—If the Association submits such standards on a timely basis, the Secretary shall review such standards to determine if the standards meet the requirements of the part. The Secretary shall complete the review of the standards not later than 90 days after the date of their submission. The Secretary shall promulgate such proposed standards to apply to organizations and products described in paragraph (1) except to the extent that the Secretary modifies such proposed standards because they do not meet such requirements.

''(3) FAILURE TO SUBMIT.—If the Association does not submit such standards on a timely basis, the Secretary shall promulgate such standards by not later than the date the Secretary would otherwise have been required to promulgate standards under paragraph (2).

''(4) USE OF INTERIM RULES.—For the period in which this part is in effect and standards are being developed and established under the preceding provisions of this subsection, the Secretary shall provide by not later than June 1, 1996, for the application of such interim standards (without regard to any requirements for notice and public comment) as may be appropriate to provide for the expedited implementation of this part. Such interim standards shall not apply after the date standards are established under the preceding provisions of this subsection.

''(b) UNION AND TAFT-HARTLEY SPONSORS, QUALIFIED ASSOCIATIONS, AND PRODUCTS.—

''(1) IN GENERAL.—The Secretary shall develop and promulgate by regulation standards consistent with the requirements of this part for union and Taft-Hartley sponsors, for qualified associations, and for MedicarePlus products offered by such organizations (other than MedicarePlus products offered by qualified associations that are issued by organizations to which section 1851(b)(1) applies).

''(2) CONSULTATION WITH LABOR.—The Secretary shall consult with the Secretary of Labor with respect to such standards for such sponsors and products.

''(3) TIMING.—Standards under this subsection shall be promulgated at or about the time standards are promulgated under subsection (a).

''(c) ESTABLISHMENT OF STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—

''(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5, United States Code, standards that entities must meet to qualify as provider-sponsored organizations under this part.

''(2) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of Medicare Preservation Act of 1995.

''(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under paragraph (2), and for purposes of this subsection, the 'target date for publication' (referred to in section 564(a)(5) of such title) shall be September 1, 1996.

''(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title under this subsection, '15 days' shall be substituted for '30 days'.

''(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

''(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

''(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

''(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than June 1, 1996, regarding the committee's progress on achieving a concensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

''(7) FINAL COMMITTEE REPORT.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

''(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

''(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.

''(10) PROCESS FOR APPROVAL OF APPLICATIONS FOR CERTIFICATION.—

''(A) IN GENERAL.—The Secretary shall establish a process for the receipt and approval of applications of entities for certification as provider-sponsored organizations under this part. Under such process, the Secretary shall act upon a complete application submitted within 60 days after the date it is received.

''(B) CIRCULATION OF PROPOSED APPLICATION FORM.—By March 1, 1996, the Secretary, after consultation with the negotiated rulemaking committee, shall circulate a proposed application form that could be used by entities considering becoming certified as a provider-sponsored organization under this part.

''(d) COORDINATION AMONG FINAL STANDARDS.—In establishing standards (other than on an interim basis) under the previous provisions of this section, the Secretary shall seek to provide for consistency (as appropriate) across the different types of MedicarePlus organizations, in order to promote equitable treatment of different types of organizations and consistent protection for individuals who elect products offered by the different types of MedicarePlus organizations.

''(e) USE OF CURRENT STANDARDS FOR INTERIM STANDARDS.—To the extent practicable and consistent with the requirements of this part, standards established on an interim basis to carry out requirements of this

part may be based on currently applicable standards, such as the rules established under section 1876 (as in effect as of the date of the enactment of this section) to carry out analogous provisions of such section or standards established or developed for application in the private health insurance market.

''(f) APPLICATION OF NEW STANDARDS TO ENTITIES WITH A CONTRACT.—In the case of a MedicarePlus organization with a contract in effect under this part at the time standards applicable to the organization under this section are changed, the organization may elect not to have such changes apply to the organization until the end of the current contract year (or, if there is less than 6 months remaining in the contract year, until 1 year after the end of the current contract year).

''(g) RELATION TO STATE LAWS.—The standards established under this section shall supersede any State law or regulation with respect to MedicarePlus products which are offered by MedicarePlus organizations and are issued by organizations to which section 1851(b)(1) applies, to the extent such law or regulation is inconsistent with such standards.

''MEDICARE-PLUS CERTIFICATION

''SEC. 1857. (a) STATE CERTIFICATION PROCESS FOR STATE-REGULATED ORGANIZATIONS.—

''(1) APPROVAL OF STATE PROCESS.—The Secretary shall approve a MedicarePlus certification and enforcement program established by a State for applying the standards established under section 1856 to MedicarePlus organizations (other than union sponsors, Taft-Hartley sponsors, and provider-sponsored organizations) and MedicarePlus products offered by such organizations if the Secretary determines that the program effectively provides for the application and enforcement of such standards in the State with respect to such organizations and products. Such program shall provide for certification of compliance of MedicarePlus organizations and products with the applicable requirements of this part not less often than once every 3 years.

''(2) EFFECT OF CERTIFICATION UNDER STATE PROCESS.—A MedicarePlus organization and MedicarePlus product offered by such an organization that is certified under such program is considered to have been certified under this subsection with respect to the offering of the product to individuals residing in the State.

''(3) USER FEES.—The State may impose user fees on organizations seeking certification under this subsection in such amounts as the State deems sufficient to finance the costs of such certification. Nothing in this paragraph shall be construed as restricting a State's authority to impose premium taxes, other taxes, or other levies.

''(4) REVIEW.—The Secretary periodically shall review State programs approved under paragraph (1) to determine if they continue to provide for certification and enforcement described in such paragraph. If the Secretary finds that a State program no longer so provides, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the State program to meet the requirements of paragraph (1). If the Secretary makes a final determination that the State program, after such an opportunity, fails to meet such requirements, the provisions of subsection (b) shall apply to MedicarePlus organizations and products in the State.

''(5) EFFECT OF NO STATE PROGRAM.—Beginning on the date standards are established under section 1856, in the case of organizations and products in States in which a certification program has not been approved and in operation under paragraph (1), the Secretary shall establish a process for the certification of MedicarePlus organizations (other than union sponsors, Taft-Hartley sponsors, and provider-sponsored organizations) and products of such organizations as meeting such standards.

''(6) PUBLICATION OF LIST OF APPROVED STATE PROGRAMS.—The Secretary shall publish (and periodically update) a list of those State programs which are approved for purposes of this subsection.

''(b) FEDERAL CERTIFICATION PROCESS FOR UNION SPONSORS, TAFT-HARTLEY SPONSORS, AND PROVIDER-SPONSORED ORGANIZATIONS.—

''(1) ESTABLISHMENT.—The Secretary shall establish a process for the certification of union sponsors, Taft-Hartley sponsors, and provider-sponsored organizations and MedicarePlus products offered by such sponsors and organizations as meeting the applicable standards established under section 1856.

''(2) INVOLVEMENT OF SECRETARY OF LABOR.—Such process shall be established and operated in cooperation with the Secretary of Labor with respect to union sponsors and Taft-Hartley sponsors.

''(3) USE OF STATE LICENSING AND PRIVATE ACCREDITATION PROCESSES.—

''(A) IN GENERAL.—The process under this subsection shall, to the maximum extent practicable, provide that MedicarePlus organizations and products that are licensed or certified through a qualified private accreditation process that the Secretary finds applies standards that are no less stringent than the requirements of this part are deemed to meet the corresponding requirements of this part for such an organization or product.

''(B) PERIODIC ACCREDITATION.—The use of an accreditation under subparagraph (A) shall be valid only for such period as the Secretary specifies.

''(4) USER FEES.—The Secretary may impose user fees on entities seeking certification under this subsection in such amounts as the Secretary deems sufficient to finance the costs of such certification.

''(c) CERTIFICATION OF PROVIDER-SPONSORED ORGANIZATIONS BY STATES.—

''(1) IN GENERAL.—The Secretary shall establish a process under which a State may propose to provide for certification of entities as meeting the requirements of this part to be provider-sponsored organizations.

''(2) CONDITIONS FOR APPROVAL.—The Secretary may not approve a State program for certification under paragraph (1) unless the Secretary determines that the certification program applies standards and requirements that are identical to the standards and requirements of this part and the applicable provisions for enforcement of such standards and requirements do not result in a lower level or quality of enforcement than that which is otherwise applicable under this title.

''(d) NOTICE TO ENROLLEES IN CASE OF DECERTIFICATION.—If a MedicarePlus organization or product is decertified under this section, the organization shall notify each enrollee with the organization and product under this part of such decertification.

''(e) QUALIFIED ASSOCIATIONS.—In the case of MedicarePlus products offered by a MedicarePlus organization that is a qualified association (as defined in section 1854(c)(4)(C)) and issued by an organization to which section 1851(b)(1) applies or by a provider-sponsored organization (as defined in section 1854(a)), nothing in this section shall be construed as limiting the authority of States to regulate such products.

''CONTRACTS WITH MEDICAREPLUS ORGANIZATIONS

''SEC. 1858. (a) IN GENERAL.—The Secretary shall not permit the election under section 1805 of a MedicarePlus product offered by a MedicarePlus organization under this part, and no payment shall be made under section 1856 to an organization, unless the Secretary has entered into a contract under this section with an organization with respect to the offering of such product. Such a contract with an organization may cover more than one MedicarePlus product. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(b) MINIMUM ENROLLMENT REQUIREMENTS.—

''(1) IN GENERAL.—Subject to paragraphs (1) and (2), the Secretary may not enter into a contract under this section with a MedicarePlus organization (other than a union sponsor or Taft-Hartley sponsor) unless the organization has at least 5,000 individuals (or 1,500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization, except that the standards under section 1856 may permit the organization to have a lesser number of beneficiaries (but not less than 500 in the case of an organization that is a provider-sponsored organization) if the organization primarily serves individuals residing outside of urbanized areas.

''(2) EXCEPTION FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—Paragraph (1) shall not apply with respect to a contract that relates only to a high deductible/medisave product.

''(3) ALLOWING TRANSITION.—The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

''(c) CONTRACT PERIOD AND EFFECTIVENESS.—

''(1) PERIOD.—Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

''(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in an applicable paragraph of subsection (g) on the MedicarePlus organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part;

''(C) is operating in a manner that is not in the best interests of the individuals covered under the contract; or

''(D) no longer substantially meets the applicable conditions of this part.

''(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under a high deductible/medisave account be effective before January 1997 with respect to such coverage.

''(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a contract with a MedicarePlus organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant

special consideration, as determined by the Secretary.

''(5) NO CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

''(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

''(1) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

''(A) shall have the right to inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

''(B) shall have the right to audit and inspect any books and records of the MedicarePlus organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

''(2) ENROLLEE NOTICE AT TIME OF TERMINATION.—Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled with the organization under this part.

''(3) DISCLOSURE.—

''(A) IN GENERAL.—Each MedicarePlus organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

''(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

''(ii) A copy of the report, if any, filed with the Health Care Financing Administration containing the information required to be reported under section 1124 by disclosing entities.

''(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

''(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

''(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

''(III) any lending of money or other extension of credit between an organization and a party in interest.

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

''(B) PARTY IN INTEREST DEFINED.—For the purposes of this paragraph, the term 'party in interest' means—

''(i) any director, officer, partner, or employee responsible for management or administration of a MedicarePlus organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a MedicarePlus organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

''(ii) any entity in which a person described in clause (i)—

''(I) is an officer or director;

''(II) is a partner (if such entity is organized as a partnership);

''(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

''(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

''(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

''(iv) any spouse, child, or parent of an individual described in clause (i).

''(C) ACCESS TO INFORMATION.—Each MedicarePlus organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

''(4) LOAN INFORMATION.—The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

''(e) ADDITIONAL CONTRACT TERMS.—The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

''(f) INTERMEDIATE SANCTIONS.—

''(1) IN GENERAL.—If the Secretary determines that a MedicarePlus organization with a contract under this section—

''(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

''(B) imposes premiums on individuals enrolled under this part in excess of the premiums permitted;

''(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

''(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

''(E) misrepresents or falsifies information that is furnished—

''(i) to the Secretary under this part, or

''(ii) to an individual or to any other entity under this part;

''(F) fails to comply with the requirements of section 1852(f)(3); or

''(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

''(2) REMEDIES.—The remedies described in this paragraph are—

''(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

''(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

''(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

''(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a MedicarePlus organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

''(A) civil money penalties of not more than $25,000 for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract;

''(B) civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under subsection (h) during which the deficiency that is the basis of a determination under subsection (c)(2) exists; and

''(C) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

''(4) PROCEDURES FOR IMPOSING SANCTIONS.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (1) or (2) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

''(g) PROCEDURES FOR IMPOSING SANCTIONS.—The Secretary may terminate a contract with a MedicarePlus organization under this section or may impose the intermediate sanctions described in subsection (f) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(1) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2);

''(2) the Secretary shall impose more severe sanctions on organizations that have a history of deficiencies or that have not taken steps to correct deficiencies the Secretary has brought to their attention;

''(3) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(4) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(b) CONFORMING REFERENCES TO PREVIOUS PART C.—Any reference in law (in effect before the date of the enactment of this Act) to part C of title XVIII of the Social Security Act is deemed a reference to part D of such title (as in effect after such date).

(c) USE OF INTERIM, FINAL REGULATIONS.—In order to carry out the amendment made by subsection (a) in a timely manner, the Secretary of Health and Human Services may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(d) ADVANCE DIRECTIVES.—Section 1866(f) (42 U.S.C. 1395cc(f)) is amended—

(1) in paragraph (1)—

(A) by inserting ''1853(g),'' after ''1833(s),'', and

(B) by inserting '', MedicarePlus organization,'' after ''provider of services'', and

(2) by adding at the end the following new paragraph:

''(4) Nothing in this subsection shall be construed to require the provision of information regarding assisted suicide, euthanasia, or mercy killing.''.

(e) CONFORMING AMENDMENT.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended by inserting before the semicolon at the end the following: ''and in the case of hospitals to accept as payment in full for inpatient hospital services that are emergency services (as defined in section 1853(b)(4)) that are covered under this title and are furnished to any individual enrolled under part C with a MedicarePlus organization which does not have a contract establishing payment amounts for services furnished to members of the organization the amounts that would be made as a payment in full under this title if the individuals were not so enrolled''.

SEC. 15003. DUPLICATION AND COORDINATION OF MEDICARE-RELATED PRODUCTS.

(a) TREATMENT OF CERTAIN HEALTH INSURANCE POLICIES AS NONDUPLICATIVE.—

(1) IN GENERAL.—Effective as if included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990, section 1882(d)(3)(A) (42 U.S.C. 1395ss(d)(3)(A)) is amended—

(A) by amending clause (i) to read as follows:

''(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title or electing a MedicarePlus product under section 1805—

''(I) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

''(II) in the case of an individual not electing a MedicarePlus product, a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy, or

''(III) in the case of an individual electing a MedicarePlus product, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or under another medicare supplemental policy.'';

(B) in clause (iii), by striking ''clause (i)'' and inserting ''clause (i)(II)''; and

(C) by adding at the end the following new clauses:

''(iv) For purposes of this subparagraph a health insurance policy shall be considered to 'duplicate' benefits under this title only when, under its terms, the policy provides specific reimbursement for identical items and services to the extent paid for under this title, and a health insurance policy providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to 'duplicate' any health benefits under this title.

''(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy), including a policy (such as a long-term care insurance contract described in section 7702B(b) of the Internal Revenue Code of 1986, as added by the Contract with America Tax Relief Act of 1995 (H.R. 1215)) providing benefits for long-term care, nursing home care, home health care, or community-based care, that coordinates against or excludes items and services available or paid for under this title and (for policies sold or issued after January 1, 1996) that discloses such coordination or exclusion in the policy's outline of coverage, is not considered to 'duplicate' health benefits under this title. For purposes of this clause, the terms 'coordinates' and 'coordination' mean, with respect to a policy in relation to health benefits under this title, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this title.

''(vi) Notwithstanding any other provision of law, no criminal or civil penalty may be imposed at any time under this subparagraph and no legal action may be brought or continued at any time in any Federal or State court if the penalty or action is based on an act or omission that occurred after November 5, 1991, and before the date of the enactment of this clause, and relates to the sale, issuance, or renewal of any health insurance policy during such period, if such policy meets the requirements of clause (iv) or (v).

''(vii) A State may not impose, with respect to the sale or issuance of a policy (or rider) that meets the requirements of this title pursuant to clause (iv) or (v) to an individual entitled to benefits under part A or enrolled under part B or enrolled under a MedicarePlus product under part C, any requirement based on the premise that such a policy or rider duplicates health benefits to which the individual is otherwise entitled under this title.''.

(2) CONFORMING AMENDMENTS.—Section 1882(d)(3) (42 U.S.C. 1395ss(d)(3)) is amended—

(A) in subparagraph (B), by inserting ''(including any MedicarePlus product)'' after ''health insurance policies'';

(B) in subparagraph (C)—

(i) by striking ''with respect to (i)'' and inserting ''with respect to'', and

(ii) by striking '', (ii) the sale'' and all that follows up to the period at the end; and

(C) by striking subparagraph (D).

(3) MEDICAREPLUS PRODUCTS NOT TREATED AS MEDICARE SUPPLEMENTARY POLICIES.—Section 1882(g) (42 U.S.C. 1395ss(g)) is amended by inserting ''a MedicarePlus product or'' after ''and does not include''

(4) REPORT ON DUPLICATION AND COORDINATION OF HEALTH INSURANCE POLICIES THAT ARE NOT MEDICARE SUPPLEMENTAL POLICIES.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall prepare and submit to Congress a report on the advisability and feasibility of restricting the sale to medicare beneficiaries of health insurance policies that duplicate (within the meaning of section 1882(d)(3)(A) of the Social Security Act) other health insurance policies that such a beneficiary may have. In preparing such report, the Secretary shall seek the advice of the National Association of Insurance Commissioners and shall take into account the standards established under section 1807 of the Social Security Act for the electronic coordination of benefits.

(b) ADDITIONAL RULES RELATING TO INDIVIDUALS ENROLLED IN MEDICAREPLUS PRODUCTS.—Section 1882 (42 U.S.C. 1395ss) is further amended by adding at the end the following new subsection:

''(u)(1) Notwithstanding the previous provisions of this section, the following provisions shall not apply to a health insurance policy (other than a medicare supplemental policy) provided to an individual who has elected the MedicarePlus option under section 1805:

''(A) Subsections (o)(1), (o)(2), (p)(1)(A)(i), (p)(2), (p)(3), (p)(8), and (p)(9) (insofar as they relate to limitations on benefits or groups of benefits that may be offered).

''(B) Subsection (r) (relating to loss-ratios).

''(2)(A) It is unlawful for a person to sell or issue a policy described in subparagraph (B) to an individual with knowledge that the individual has in effect under section 1805 an election of a high deductible/medisave product.

''(B) A policy described in this subparagraph is a health insurance policy that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the high deductible/medisave product.''.

SEC. 15004. TRANSITIONAL RULES FOR CURRENT MEDICARE HMO PROGRAM.

(a) TRANSITION FROM CURRENT CONTRACTS.—

(1) LIMITATION ON NEW CONTRACTS.—

(A) NO NEW RISK-SHARING CONTRACTS AFTER NEW STANDARDS ESTABLISHED.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall not enter into any risk-sharing contract under section 1876 of the Social Security Act with an eligible organization for any contract year beginning on or after the date standards for MedicarePlus organizations and products are first established under section 1856(a) of such Act with respect to MedicarePlus organizations that are insurers or health maintenance organizations unless such a contract had been in effect under section 1876 of such Act for the organization for the previous contract year.

(B) NO NEW COST REIMBURSEMENT CONTRACTS.—The Secretary shall not enter into any cost reimbursement contract under section 1876 of the Social Security Act beginning for any contract year beginning on or after the date of the enactment of this Act.

(2) TERMINATION OF CURRENT CONTRACTS.—

(A) RISK-SHARING CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall not extend or continue any risk-sharing contract with an eligible organization under section 1876 of the Social Security Act (for which a contract was entered into consistent with paragraph (1)(A)) for any contract year beginning on or after 1 year after the date standards described in paragraph (1)(A) are established.

(B) COST REIMBURSEMENT CONTRACTS.—The Secretary shall not extend or continue any reasonable cost reimbursement contract with an eligible organization under section 1876 of the Social Security Act for any contract year beginning on or after January 1, 1998.

(b) CONFORMING PAYMENT RATES.—

(1) RISK-SHARING CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall provide that payment amounts under risk-sharing contracts under section 1876(a) of the Social Security Act for months in a year (beginning with January 1996) shall be computed—

(A) with respect to individuals entitled to benefits under both parts A and B of title XVIII of such Act, by substituting payment

rates under section 1855(a) of such Act for the payment rates otherwise established under section 1876(a) of such Act, and

(B) with respect to individuals only entitled to benefits under part B of such title, by substituting an appropriate proportion of such rates (reflecting the relative proportion of payments under such title attributable to such part) for the payment rates otherwise established under section 1876(a) of such Act.

For purposes of carrying out this paragraph for payment for months in 1996, the Secretary shall compute, announce, and apply the payment rates under section 1855(a) of such Act (notwithstanding any deadlines specified in such section) in as timely a manner as possible and may (to the extent necessary) provide for retroactive adjustment in payments made not in accordance with such rates.

(2) COST CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall provide that payment amounts under cost reimbursement contracts under section 1876(a) of the Social Security Act shall take into account adjustments in payment amounts made in parts A and B of title XVIII of such Act pursuant to the amendments made by this title.

(c) ELIMINATION OF 50:50 RULE.—

(1) IN GENERAL.—Section 1876 (42 U.S.C. 1395mm) is amended by striking subsection (f).

(2) CONFORMING AMENDMENTS.—Section 1876 is further amended—

(A) in subsection (c)(3)(A)(i), by striking ''would result in failure to meet the requirements of subsection (f) or'', and

(B) in subsection (i)(1)(C), by striking ''(e), and (f)'' and inserting ''and (e)''.

(3) EFFECTIVE DATE.—The amendments made by this section shall apply to contract years beginning on or after January 1, 1996.

PART 2—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

SEC. 15011. MEDICAREPLUS MSA'S.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to amounts specifically excluded from gross income) is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

''SEC. 137. MEDICAREPLUS MSA'S.

''(a) EXCLUSION.—Gross income shall not include any payment to the MedicarePlus MSA of an individual by the Secretary of Health and Human Services under section 1855(f)(1)(B) of the Social Security Act.

''(b) MEDICAREPLUS MSA.—For purposes of this section—

''(1) MEDICAREPLUS MSA.—The term 'MedicarePlus MSA' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

''(A) Except in the case of a trustee-to-trustee transfer described in subsection (d)(4), no contribution will be accepted unless it is made by the Secretary of Health and Human Services under section 1855(f)(1)(B) of the Social Security Act.

''(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

''(C) No part of the trust assets will be invested in life insurance contracts.

''(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(E) The interest of an individual in the balance in his account is nonforfeitable.

''(F) Trustee-to-trustee transfers described in subsection (d)(4) may be made to and from the trust.

''(2) QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an account holder, amounts paid by such holder—

''(i) for medical care (as defined in section 213(d)) for the account holder, but only to the extent such amounts are not compensated for by insurance or otherwise, or

''(ii) for long-term care insurance for the account holder.

''(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Subparagraph (A)(i) shall not apply to any payment for insurance.

''(3) ACCOUNT HOLDER.—The term 'account holder' means the individual on whose behalf the MedicarePlus MSA is maintained.

''(4) CERTAIN RULES TO APPLY.—Rules similar to the rules of subsections (g) and (h) of section 408 shall apply for purposes of this section.

''(c) TAX TREATMENT OF ACCOUNTS.—

''(1) IN GENERAL.—A MedicarePlus MSA is exempt from taxation under this subtitle unless such MSA has ceased to be a MedicarePlus MSA by reason of paragraph (2). Notwithstanding the preceding sentence, any such MSA is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

''(2) ACCOUNT ASSETS TREATED AS DISTRIBUTED IN THE CASE OF PROHIBITED TRANSACTIONS OR ACCOUNT PLEDGED AS SECURITY FOR LOAN.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to MedicarePlus MSA's, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

''(d) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—No amount shall be included in the gross income of the account holder by reason of a payment or distribution from a MedicarePlus MSA which is used exclusively to pay the qualified medical expenses of the account holder. Any amount paid or distributed from a MedicarePlus MSA which is not so used shall be included in the gross income of such holder.

''(2) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES IF MINIMUM BALANCE NOT MAINTAINED.—

''(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a MedicarePlus MSA which is not used exclusively to pay the qualified medical expenses of the account holder shall be increased by 50 percent of the excess (if any) of—

''(i) the amount of such payment or distribution, over

''(ii) the excess (if any) of—

''(I) the fair market value of the assets in the MedicarePlus MSA as of the close of the calendar year preceding the calendar year in which the taxable year begins, over

''(II) an amount equal to 60 percent of the deductible under the high deductible/medisave product covering the account holder as of January 1 of the calendar year in which the taxable year begins.

''(B) EXCEPTIONS.—Subparagraph (A) shall not apply if the payment or distribution is made on or after the date the account holder—

''(i) becomes disabled within the meaning of section 72(m)(7), or

''(ii) dies.

''(C) SPECIAL RULES.—For purposes of subparagraph (A)—

''(i) all MedicarePlus MSA's of the account holder shall be treated as 1 account,

''(ii) all payments and distributions not used exclusively to pay the qualified medical expenses of the account holder during any taxable year shall be treated as 1 distribution, and

''(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

''(3) WITHDRAWAL OF ERRONEOUS CONTRIBUTIONS.—Paragraphs (1) and (2) shall not apply to any payment or distribution from a MedicarePlus MSA to the Secretary of Health and Human Services of an erroneous contribution to such MSA and of the net income attributable to such contribution.

''(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Paragraphs (1) and (2) shall not apply to any trustee-to-trustee transfer from a MedicarePlus MSA of an account holder to another MedicarePlus MSA of such account holder.

''(5) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any payment or distribution out of a MedicarePlus MSA for qualified medical expenses shall not be treated as an expense paid for medical care.

''(e) TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—

''(1) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—

''(A) IN GENERAL.—In the case of an account holder's interest in a MedicarePlus MSA which is payable to (or for the benefit of) such holder's spouse upon the death of such holder, such MedicarePlus MSA shall be treated as a MedicarePlus MSA of such spouse as of the date of such death.

''(B) SPECIAL RULES IF SPOUSE NOT MEDICARE ELIGIBLE.—If, as of the date of such death, such spouse is not entitled to benefits under title XVIII of the Social Security Act, then after the date of such death—

''(i) the Secretary of Health and Human Services may not make any payments to such MedicarePlus MSA, other than payments attributable to periods before such date,

''(ii) in applying subsection (b)(2) with respect to such MedicarePlus MSA, references to the account holder shall be treated as including references to any dependent (as defined in section 152) of such spouse and any subsequent spouse of such spouse, and

''(iii) in lieu of applying subsection (d)(2), the rules of section 220(f)(2) shall apply.

''(2) TREATMENT IF DESIGNATED BENEFICIARY IS NOT SPOUSE.—In the case of an account holder's interest in a MedicarePlus MSA which is payable to (or for the benefit of) any person other than such holder's spouse upon the death of such holder—

''(A) such account shall cease to be a MedicarePlus MSA as of the date of death, and

''(B) an amount equal to the fair market value of the assets in such account on such date shall be includible—

''(i) if such person is not the estate of such holder, in such person's gross income for the taxable year which includes such date, or

''(ii) if such person is the estate of such holder, in such holder's gross income for last taxable year of such holder.

''(f) REPORTS.—

''(1) IN GENERAL.—The trustee of a MedicarePlus MSA shall make such reports regarding such account to the Secretary and to the account holder with respect to—

''(A) the fair market value of the assets in such MedicarePlus MSA as of the close of each calendar year, and

''(B) contributions, distributions, and other matters,

as the Secretary may require by regulations.

''(2) TIME AND MANNER OF REPORTS.—The reports required by this subsection—

''(A) shall be filed at such time and in such manner as the Secretary prescribes in such regulations, and

''(B) shall be furnished to the account holder—

''(i) not later than January 31 of the calendar year following the calendar year to which such reports relate, and

''(ii) in such manner as the Secretary prescribes in such regulations.''

(b) EXCLUSION OF MEDICAREPLUS MSA'S FROM ESTATE TAX.—Part IV of subchapter A of chapter 11 of such Code is amended by adding at the end the following new section:

''SEC. 2057. MEDICAREPLUS MSA'S.

''For purposes of the tax imposed by section 2001, the value of the taxable estate shall be determined by deducting from the value of the gross estate an amount equal to the value of any MedicarePlus MSA (as defined in section 137(b)) included in the gross estate.''

(c) TAX ON PROHIBITED TRANSACTIONS.—

(1) Section 4975 of such Code (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraph:

''(4) SPECIAL RULE FOR MEDICAREPLUS MSA'S.—An individual for whose benefit a MedicarePlus MSA (within the meaning of section 137(b)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a MedicarePlus MSA by reason of the application of section 137(c)(2) to such account.''

(2) Paragraph (1) of section 4975(e) of such Code is amended to read as follows:

''(1) PLAN.—For purposes of this section, the term 'plan' means—

''(A) a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a),

''(B) an individual retirement account described in section 408(a),

''(C) an individual retirement annuity described in section 408(b),

''(D) a medical savings account described in section 220(d),

''(E) a MedicarePlus MSA described in section 137(b), or

''(F) a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be described in any preceding subparagraph of this paragraph.''

(d) FAILURE TO PROVIDE REPORTS ON MEDICAREPLUS MSA'S.—

(1) Subsection (a) of section 6693 of such Code (relating to failure to provide reports on individual retirement accounts or annuities) is amended to read as follows:

''(a) REPORTS.—

''(1) IN GENERAL.—If a person required to file a report under a provision referred to in paragraph (2) fails to file such report at the time and in the manner required by such provision, such person shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.

''(2) PROVISIONS.—The provisions referred to in this paragraph are—

''(A) subsections (i) and (l) of section 408 (relating to individual retirement plans),

''(B) section 220(h) (relating to medical savings accounts), and

''(C) section 137(f) (relating to MedicarePlus MSA's).''

(2) The section heading for section 6693 of such Code is amended to read as follows:

''SEC. 6693. FAILURE TO FILE REPORTS ON INDIVIDUAL RETIREMENT PLANS AND CERTAIN OTHER TAX-FAVORED ACCOUNTS; PENALTIES RELATING TO DESIGNATED NONDEDUCTIBLE CONTRIBUTIONS.''

(e) CLERICAL AMENDMENTS.—

(1) The table of sections for part III of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

''Sec. 137. MedicarePlus MSA's.

''Sec. 138. Cross references to other Acts.''

(2) The table of sections for part 1 of subchapter B of chapter 68 of such Code is amended by striking the item relating to section 6693 and inserting the following new item:

''Sec. 6693. Failure to file reports on individual retirement plans and certain other tax-favored accounts; penalties relating to designated nondeductible contributions.''

(3) The table of sections for part IV of subchapter A of chapter 11 of such Code is amended by adding at the end the following new item:

''Sec. 2057. MedicarePlus MSA's.''

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

SEC. 15012. CERTAIN REBATES EXCLUDED FROM GROSS INCOME.

(a) IN GENERAL.—Section 105 of the Internal Revenue Code of 1986 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

''(j) CERTAIN REBATES UNDER SOCIAL SECURITY ACT.—Gross income does not include any rebate received under section 1852(e)(1)(A) of the Social Security Act during the taxable year.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts received after the date of the enactment of this Act.

PART 3—SPECIAL ANTITRUST RULE FOR PROVIDER SERVICE NETWORKS

SEC. 15021. APPLICATION OF ANTITRUST RULE OF REASON TO PROVIDER SERVICE NETWORKS.

(a) RULE OF REASON STANDARD.—In any action under the antitrust laws, or under any State law similar to the antitrust laws—

(1) the conduct of a provider service network in negotiating, making, or performing a contract (including the establishment and modification of a fee schedule and the development of a panel of physicians), to the extent such contract is for the purpose of providing health care services to individuals under the terms of a MedicarePlus PSO product, and

(2) the conduct of any member of such network for the purpose of providing such health care services under such contract to such extent,

shall not be deemed illegal per se. Such conduct shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including the effects on competition in properly defined markets.

(b) DEFINITIONS.—For purposes of subsection (a):

(1) ANTITRUST LAWS.—The term ''antitrust laws'' has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

(2) HEALTH CARE PROVIDER.—The term ''health care provider'' means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(3) HEALTH CARE SERVICE.—The term ''health care service'' means any service for which payment may be made under a MedicarePlus PSO product including services related to the delivery or administration of such service.

(4) MEDICAREPLUS PROGRAM.—The term ''MedicarePlus program'' means the program under part C of title XVIII of the Social Security Act.

(5) MEDICAREPLUS PSO PRODUCT.—The term ''MedicarePlus PSO product'' means a MedicarePlus product offered by a provider-sponsored organization under part C of title XVIII of the Social Security Act.

(6) PROVIDER SERVICE NETWORK.—The term ''provider service network'' means an organization that—

(A) is organized by, operated by, and composed of members who are health care providers and for purposes that include providing health care services,

(B) is funded in part by capital contributions made by the members of such organization,

(C) with respect to each contract made by such organization for the purpose of providing a type of health care service to individuals under the terms of a MedicarePlus PSO product—

(i) requires all members of such organization who engage in providing such type of health care service to agree to provide health care services of such type under such contract,

(ii) receives the compensation paid for the health care services of such type provided under such contract by such members, and

(iii) provides for the distribution of such compensation,

(D) has established, consistent with the requirements of the MedicarePlus program for provider-sponsored organizations, a program to review, pursuant to written guidelines, the quality, efficiency, and appropriateness of treatment methods and setting of services for all health care providers and all patients participating in such product, along with internal procedures to correct identified deficiencies relating to such methods and such services,

(E) has established, consistent with the requirements of the MedicarePlus program for provider-sponsored organizations, a program to monitor and control utilization of health care services provided under such product, for the purpose of improving efficient, appropriate care and eliminating the provision of unnecessary health care services,

(F) has established a management program to coordinate the delivery of health care services for all health care providers and all patients participating in such product, for the purpose of achieving efficiencies and enhancing the quality of health care services provided, and

(G) has established, consistent with the requirements of the MedicarePlus program for provider-sponsored organizations, a grievance and appeal process for such organization designed to review and promptly resolve beneficiary or patient grievances and complaints.

Such term may include a provider-sponsored organization.

(7) PROVIDER-SPONSORED ORGANIZATION.—The term ''provider-sponsored organization'' means a MedicarePlus organization under the MedicarePlus program that is a provider-sponsored organization (as defined in section ___ of the Social Security Act).

(8) STATE.—The term ''State'' has the meaning given it in section 4G(2) of the Clayton Act (15 U.S.C. 15g(2)).

(c) ISSUANCE OF GUIDELINES.—Not later than 120 days after the date of the enactment of this Act, the Attorney General and the Federal Trade Commission shall issue jointly guidelines specifying the enforcement policies and analytical principles that will be applied by the Department of Justice and the Commission with respect to the operation of subsection (a).

PART 4—COMMISSIONS

SEC. 15031. MEDICARE PAYMENT REVIEW COMMISSION.

(a) IN GENERAL.—Title XVIII, as amended by section 15001(a), is amended by inserting after section 1805 the following new section:

''MEDICARE PAYMENT REVIEW COMMISSION

''SEC. 1806. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Review Commission (in this section referred to as the 'Commission').

''(b) DUTIES.—

''(1) GENERAL DUTIES AND REPORTS.—

''(A) IN GENERAL.—The Commission shall review, and make recommendations to Congress concerning, payment policies under this title.

''(B) ANNUAL REPORTS.—By not later than June 1 of each year, the Commission shall submit a report to Congress containing an examination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program.

''(C) ADDITIONAL REPORTS.—The Commission may submit to Congress from time to time such other reports as the Commission deems appropriate. By not later than May 1, 1997, the Commission shall submit to Congress a report on the matter described in paragraph (2)(G).

''(D) SECRETARIAL RESPONSE IN RULEMAKING.—The Secretary shall respond to recommendations of the Commission in notices of rulemaking proceedings under this title.

''(2) SPECIFIC DUTIES RELATING TO MEDICAREPLUS PROGRAM.—Specifically, the Commission shall review, with respect to the MedicarePlus program under part C—

''(A) the appropriateness of the methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas);

''(B) the appropriateness of the mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries;

''(C) the implications of risk selection both among MedicarePlus organizations and between the MedicarePlus option and the non-MedicarePlus option;

''(D) in relation to payment under part C, the development and implementation of mechanisms to assure the quality of care for those enrolled with MedicarePlus organizations;

''(F) the impact of the MedicarePlus program on access to care for medicare beneficiaries;

''(G) the feasibility and desirability of extending the rules for open enrollment that apply during the transition period to apply in each county during the first 2 years in which MedicarePlus products are made available to individuals residing in the county; and

''(H) other major issues in implementation and further development of the MedicarePlus program.

''(3) SPECIFIC DUTIES RELATING TO THE FAILSAFE BUDGET MECHANISM.—Specifically, the Commission shall review, with respect to the failsafe budget mechanism described in section 1895—

''(A) the appropriateness of the expenditure projections by the Secretary under section 1895(c) for each medicare sector;

''(B) the appropriateness of the growth factors for each sector and the ability to take into account substitution across sectors;

''(C) the appropriateness of the mechanisms for implementing reductions in payment amounts for different sectors, including any adjustments to reflect changes in volume or intensity resulting for any payment reductions;

''(D) the impact of the mechanism on provider participation in parts A and B and in the MedicarePlus program; and

''(E) the appropriateness of the medicare benefit budget (under section 1895(c)(2)(C) of the Social Security Act), particularly for fiscal years after fiscal year 2002.

''(4) SPECIFIC DUTIES RELATING TO THE FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

''(A) the factors affecting expenditures for services in different sectors, including the process for updating hospital, physician, and other fees,

''(B) payment methodologies; and

''(C) the impact of payment policies on access and quality of care for medicare beneficiaries.

''(5) SPECIFIC DUTIES RELATING TO INTERACTION OF PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically the Commission shall review the effect of payment policies under this title on the delivery of health care services under this title and assess the implications of changes in the health services market on the medicare program.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members appointed by the Comptroller General.

''(2) QUALIFICATIONS.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives, including physicians and other health professionals, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

''(3) CONSIDERATIONS IN INITIAL APPOINTMENT.—To the extent possible, in first appointing members to the Commission the Comptroller General shall consider appointing individuals who (as of the date of the enactment of this section) were serving on the Prospective Payment Assessment Commission or the Physician Payment Review Commission.

''(4) TERMS.—

''(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

''(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

''(5) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

''(6) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment.

''(7) MEETINGS.—The Commission shall meet at the call of the Chairman.

''(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

''(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(4) make advance, progress, and other payments which relate to the work of the Commission;

''(5) provide transportation and subsistence for persons serving without compensation; and

''(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

''(e) POWERS.—

''(1) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

''(2) DATA COLLECTION.—In order to carry out its functions, the Commission shall collect and assess information.

''(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

''(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

''(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

''(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon request.

''(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the General Accounting Office.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

''(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. 60 percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.''.

(b) ABOLITION OF PROPAC AND PPRC.—

(1) PROPAC.—

(A) IN GENERAL.—Section 1886(e) (42 U.S.C. 1395ww(e)) is amended—

(i) by striking paragraphs (2) and (6); and

(ii) in paragraph (3), by striking ''(A) The Commission'' and all that follows through ''(B)''.

(B) CONFORMING AMENDMENT.—Section 1862 (42 U.S.C. 1395y) is amended by striking ''Prospective Payment Assessment Commission'' each place it appears in subsection (a)(1)(D) and subsection (i) and inserting ''Medicare Payment Review Commission''.

(2) PPRC.—

(A) IN GENERAL.—Title XVIII is amended by striking section 1845 (42 U.S.C. 1395w–1).

(B) CONFORMING AMENDMENTS.—

(i) Section 1834(b)(2) (42 U.S.C. 1395m(b)(2)) is amended by striking ''Physician Payment Review Commission'' and inserting ''Medicare Payment Review Commission''.

(ii) Section 1842(b) (42 U.S.C. 1395u(b)) is amended by striking ''Physician Payment Review Commission'' each place it appears in paragraphs (9)(D) and (14)(C)(i) and inserting ''Medicare Payment Review Commission''.

(iii) Section 1848 (42 U.S.C. 1395w@4) is amended by striking ''Physician Payment Review Commission'' and inserting ''Medicare Payment Review Commission'' each place it appears in paragraph (2)(A)(ii), (2)(B)(iii), and (5) of subsection (c), subsection (d)(2)(F), paragraphs (1)(B), (3), and (4)(A) of subsection (f), and paragraphs (6)(C) and (7)(C) of subsection (g).

(c) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Review Commission (in this subsection referred to as ''MPRC'') by not later than March 31, 1996.

(2) TRANSITION.—Effective on a date (not later than 30 days after the date a majority of members of the MPRC have first been appointed, the Prospective Payment Assessment Commission (in this subsection referred to as ''ProPAC'') and the Physician Payment Review Commission (in this subsection referred to as ''PPRC''), and amendments made by subsection (b), are terminated. The Comptroller General, to the maximum extent feasible, shall provide for the transfer to the MPRC of assets and staff of ProPAC and PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or PPRC for any period shall be available to the MPRC for such period for like purposes.

(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MPRC shall be responsible for the preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MPRC) by the ProPAC and PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MPRC, to refer to the MPRC.

SEC. 15032. COMMISSION ON THE EFFECT OF THE BABY BOOM GENERATION ON THE MEDICARE PROGRAM.

(a) ESTABLISHMENT.—There is established a commission to be known as the Commission on the Effect of the Baby Boom Generation on the Medicare Program (in this section referred to as the ''Commission'').

(b) DUTIES.—

(1) IN GENERAL.—The Commission shall—

(A) examine the financial impact on the medicare program of the significant increase in the number of medicare eligible individuals which will occur beginning approximately during 2010 and lasting for approximately 25 years, and

(B) make specific recommendations to the Congress respecting a comprehensive approach to preserve the medicare program for the period during which such individuals are eligible for medicare.

(2) CONSIDERATIONS IN MAKING RECOMMENDATIONS.—In making its recommendations, the Commission shall consider the following:

(A) The amount and sources of Federal funds to finance the medicare program, including the potential use of innovative financing methods.

(B) The most efficient and effective manner of administering the program, including the appropriateness of continuing the application of the failsafe budget mechanism under section 1895 of the Social Security Act for fiscal years after fiscal year 2002 and the appropriate long-term growth rates for contributions electing coverage under MedicarePlus under part C of title XVIII of such Act.

(C) Methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals.

(D) Modifying age-based eligibility to correspond to changes in age-based eligibility under the OASDI program.

(E) Trends in employment-related health care for retirees, including the use of medical savings accounts and similar financing devices.

(c) MEMBERSHIP.—

(1) APPOINTMENT.—The Commission shall be composed of 15 members appointed as follows:

(A) The President shall appoint 3 members.

(B) The Majority Leader of the Senate shall appoint, after consultation with the minority leader of the Senate, 6 members, of whom not more than 4 may be of the same political party.

(C) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Representatives, 6 members, of whom not more than 4 may be of the same political party.

(2) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a Chairman and Vice Chairman from among its members.

(3) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(4) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(5) MEETINGS.—The Commission shall meet at the call of its Chairman or a majority of its members.

(6) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

(d) STAFF AND CONSULTANTS.—

(1) STAFF.—The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(2) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

(e) POWERS.—

(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(2) STUDIES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(A) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may

be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) ACCEPTANCE OF DONATIONS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(10) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.

(f) REPORT.—Not later than May 1, 1997, the Commission shall submit to Congress a report containing its findings and recommendations regarding how to protect and preserve the medicare program in a financially solvent manner until 2030 (or, if later, throughout the period of projected solvency of the Federal Old-Age and Survivors Insurance Trust Fund). The report shall include detailed recommendations for appropriate legislative initiatives respecting how to accomplish this objective.

(g) TERMINATION.—The Commission shall terminate 60 days after the date of submission of the report required in subsection (f).

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,500,000 to carry out this section. Amounts appropriated to carry out this section shall remain available until expended.

SEC. 15033. CHANGE IN APPOINTMENT OF ADMINISTRATOR OF HCFA.

(a) IN GENERAL.—Section 1117 (42 U.S.C. 1317) is amended by striking ''President by and with the advice and consent of the Senate'' and inserting ''Secretary of Health and Human Services''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to Administrators appointed on or after the date of the enactment of this Act.

PART 5—TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS

SEC. 15041. TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS.

(a) IN GENERAL.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (n) as subsection (o) and by inserting after subsection (m) the following new subsection:

''(n) TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS.—An organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of subsection (c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization (as defined in section 1854(a)(1) of the Social Security Act), whether or not the provider-sponsored organization is exempt from tax. For purposes of subsection (c)(3), any person with a material financial interest in such a provider-sponsored organization shall be treated as a private shareholder or individual with respect to the hospital.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

Subtitle B—Preventing Fraud and Abuse

PART 1—GENERAL PROVISIONS

SEC. 15101. INCREASING AWARENESS OF FRAUD AND ABUSE.

(a) BENEFICIARY OUTREACH EFFORTS.—The Secretary of Health and Human Services (acting through the Administrator of the Health Care Financing Administration and the Inspector General of the Department of Health and Human Services) shall make ongoing efforts (through public service announcements, publications, and other appropriate methods) to alert individuals entitled to benefits under the medicare program of the existence of fraud and abuse committed against the program and the costs to the program of such fraud and abuse, and of the existence of the toll-free telephone line operated by the Secretary to receive information on fraud and abuse committed against the program.

(b) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—The Secretary shall provide an explanation of benefits under the medicare program with respect to each item or service for which payment may be made under the program which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to the item or service.

(c) PROVIDER OUTREACH EFFORTS; PUBLICATION OF FRAUD ALERTS.—

(1) SPECIAL FRAUD ALERTS.—

(A) IN GENERAL.—

(i) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Secretary to issue and publish a special fraud alert.

(ii) SPECIAL FRAUD ALERT DEFINED.—In this section, a ''special fraud alert'' is a notice which informs the public of practices which the Secretary considers to be suspect or of particular concern under the medicare program or a State health care program (as defined in section 1128(h) of the Social Security Act).

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—

(i) INVESTIGATION.—Upon receipt of a request for a special fraud alert under subparagraph (A), the Secretary shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Secretary (in consultation with the Attorney General) shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(ii) CRITERIA FOR ISSUANCE.—In determining whether to issue a special fraud alert upon a request under subparagraph (A), the Secretary may consider—

(I) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in 15214(b); and

(II) the extent and frequency of the conduct that would be identified in the special fraud alert.

(2) PUBLICATION OF ALL HCFA FRAUD ALERTS IN FEDERAL REGISTER.—Each notice issued by the Health Care Financing Administration which informs the public of practices which the Secretary considers to be suspect or of particular concern under the medicare program or a State health care program (as defined in section 1128(h) of the Social Security Act) shall be published in the Federal Register, without regard to whether or not the notice is issued by a regional office of the Health Care Financing Administration.

SEC. 15102. BENEFICIARY INCENTIVE PROGRAMS.

(a) PROGRAM TO COLLECT INFORMATION ON FRAUD AND ABUSE.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary of Health and Human Services (hereinafter in this subtitle referred to as the ''Secretary'') shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1128, section 1128A, or section 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the medicare program for which there is a sanction provided under law. The program shall discourage provision of, and not consider, information which is frivolous or otherwise not relevant or material to the imposition of such a sanction.

(2) PAYMENT OF PORTION OF AMOUNTS COLLECTED.—If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than any amount paid as a penalty under section 1128B of the Social Security Act), the Secretary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(b) PROGRAM TO COLLECT INFORMATION ON PROGRAM EFFICIENCY.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

SEC. 15103. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting the following: ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section;

''(C) is operating in a manner that is not in the best interests of the individuals covered under the contract; or

''(D) no longer substantially meets the applicable conditions of subsections (b), (c), and (e).''.

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is

not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract;

''(ii) civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists; and

''(iii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1);

''(B) the Secretary shall impose more severe sanctions on organizations that have a history of deficiencies or that have not taken steps to correct deficiencies the Secretary has brought to their attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(4) CONFORMING AMENDMENTS.—(A) Section 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(B) Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is further amended by adding at the end the following new subparagraph:

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) or (B) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1996.

SEC. 15104. VOLUNTARY DISCLOSURE PROGRAM.

Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

''VOLUNTARY DISCLOSURE OF ACTS OR OMISSIONS

''SEC. 1129. (a) ESTABLISHMENT OF VOLUNTARY DISCLOSURE PROGRAM.—Not later than 3 months after the date of the enactment of this section, the Secretary shall establish a program to encourage individuals and entities to voluntarily disclose to the Secretary information on acts or omissions of the individual or entity which constitute grounds for the imposition of a sanction described in section 1128, 1128A, or 1128B.

''(b) EFFECT OF VOLUNTARY DISCLOSURE.—If an individual or entity voluntarily discloses information with respect to an act or omission to the Secretary under subsection (a), the following rules shall apply:

''(1) The Secretary may waive, reduce, or otherwise mitigate any sanction which would otherwise be applicable to the individual or entity under section 1128, 1128A, or 1128B as a result of the act or omission involved.

''(2) No qui tam action may be brought pursuant to chapter 37 of title 31, United States Code, against the individual or entity with respect to the act or omission involved.''.

SEC. 15105. REVISIONS TO CURRENT SANCTIONS.

(a) DOUBLING THE AMOUNT OF CIVIL MONETARY PENALTIES.—The maximum amount of civil monetary penalties specified in section 1128A of the Social Security Act or under title XVIII of such Act (as in effect on the day before the date of the enactment of this Act) shall, effective for violations occurring after the date of the enactment of this Act, be double the amount otherwise provided as of such date.

(b) ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION.—Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

''(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to acts or omissions occurring on or after January 1, 1996.

SEC. 15106. DIRECT SPENDING FOR ANTI-FRAUD ACTIVITIES UNDER MEDICARE.

(a) ESTABLISHMENT OF MEDICARE INTEGRITY PROGRAM.—Title XVIII is amended by adding at the end the following new section:

''MEDICARE INTEGRITY PROGRAM

''SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (hereafter in this section referred to as the 'Program') under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible private entities to carry out the activities described in subsection (b).

''(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

''(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).

''(2) Audit of cost reports.

''(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

''(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

''(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

''(1) the entity has demonstrated capability to carry out such activities;

''(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General of the United States, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities;

''(3) the entity's financial holdings, interests, or relationships will not interfere with its ability to perform the functions to be required by the contract in an effective and impartial manner; and

''(4) the entity meets such other requirements as the Secretary may impose.

''(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary may by regulation establish, except that such procedures shall include the following:

''(1) The Secretary shall determine the appropriate number of separate contracts which are necessary to carry out the Program and the appropriate times at which the Secretary shall enter into such contracts.

''(2) The provisions of section 1153(e)(1) shall apply to contracts and contracting authority under this section, except that competitive procedures must be used when entering into new contracts under this section, or at any other time considered appropriate by the Secretary.

''(3) A contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

''(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

''(f) TRANSFER OF AMOUNTS TO MEDICARE ANTI-FRAUD AND ABUSE TRUST FUND.—For each fiscal year, the Secretary shall transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Medicare Anti-Fraud and Abuse Trust Fund under subsection (g) such amounts as are necessary to carry out the activities described in subsection (b). Such transfer shall be in an allocation as reasonably reflects the proportion of such expenditures associated with part A and part B.

''(g) MEDICARE ANTI-FRAUD AND ABUSE TRUST FUND.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—There is hereby established in the Treasury of the United States the Anti-Fraud and Abuse Trust Fund (hereafter in this subsection referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as

provided in subparagraph (B) and such amounts as may be deposited in the Trust Fund as provided in subsection (f), paragraph (3), and title XI.

''(B) AUTHORIZATION TO ACCEPT GIFTS AND BEQUESTS.—The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Trust Fund or any activity financed through the Trust Fund.

''(2) INVESTMENT.—

''(A) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund in government account serial securities.

''(B) USE OF INCOME.—Any interest derived from investments under subparagraph (A) shall be credited to the Fund.

''(3) AMOUNTS DEPOSITED INTO TRUST FUND.—In addition to amounts transferred under subsection (f), there shall be deposited in the Trust Fund—

''(A) that portion of amounts recovered in relation to section 1128A arising out of a claim under title XVIII as remains after application of subsection (f)(2) (relating to repayment of the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund) of that section, as may be applicable,

''(B) fines imposed under section 1128B arising out of a claim under this title, and

''(C) penalties and damages imposed (other than funds awarded to a relator or for restitution) under sections 3729 through 3732 of title 31, United States Code (pertaining to false claims) in cases involving claims relating to programs under title XVIII, XIX, or XXI.

''(4) DIRECT APPROPRIATION OF FUNDS TO CARRY OUT PROGRAM.—

''(A) IN GENERAL.—There are appropriated from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under this section, subject to subparagraph (B).

''(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

''(i) For fiscal year 1996, such amount shall be not less than $430,000,000 and not more than $440,000,000.

''(ii) For fiscal year 1997, such amount shall be not less than $490,000,000 and not more than $500,000,000.

''(iii) For fiscal year 1998, such amount shall be not less than $550,000,000 and not more than $560,000,000.

''(iv) For fiscal year 1999, such amount shall be not less than $620,000,000 and not more than $630,000,000.

''(v) For fiscal year 2000, such amount shall be not less than $670,000,000 and not more than $680,000,000.

''(vi) For fiscal year 2001, such amount shall be not less than $690,000,000 and not more than $700,000,000.

''(vii) For fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

''(5) ANNUAL REPORT.—The Secretary shall submit an annual report to Congress on the amount of revenue which is generated and disbursed by the Trust Fund in each fiscal year.''.

(b) ELIMINATION OF FI AND CARRIER RESPONSIBILITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PROGRAM.—

(1) RESPONSIBILITIES OF FISCAL INTERMEDIARIES UNDER PART A.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

''(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.''.

(2) RESPONSIBILITIES OF CARRIERS UNDER PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

''(6) No carrier may carry out (or receive payment for carrying out) any activity pursuant to a contract under this subsection to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.''.

(c) CONFORMING AMENDMENT.—Section 1128A(f)(3) (42 U.S.C. 1320a–7a(f)(3)) is amended by striking ''as miscellaneous receipts of the Treasury of the United States'' and inserting ''in the Anti-Fraud and Abuse Trust Fund established under section 1893(g)''.

(d) DIRECT SPENDING FOR MEDICARE-RELATED ACTIVITIES OF INSPECTOR GENERAL.—Section 1893, as added by subsection (a), is amended by adding at the end the following new subsection:

''(h) DIRECT SPENDING FOR MEDICARE-RELATED ACTIVITIES OF INSPECTOR GENERAL.—

''(1) IN GENERAL.—There are appropriated from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Inspector General of the Department of Health and Human Services for each fiscal year such amounts as are necessary to enable the Inspector General to carry out activities relating to the medicare program (as described in paragraph (2)), subject to paragraph (3).

''(2) ACTIVITIES DESCRIBED.—The activities described in this paragraph are as follows:

''(A) Prosecuting medicare-related matters through criminal, civil, and administrative proceedings.

''(B) Conducting investigations relating to the medicare program.

''(C) Performing financial and performance audits of programs and operations relating to the medicare program.

''(D) Performing inspections and other evaluations relating to the medicare program.

''(E) Conducting provider and conumer education activities regarding the requirements of this title.

''(3) AMOUNTS SPECIFIED.—The amount appropriated under paragraph (1) for a fiscal year is as follows:

''(A) For fiscal year 1996, such amount shall be $130,000,000.

''(B) For fiscal year 1997, such amount shall be $181,000,000.

''(C) For fiscal year 1998, such amount shall be $204,000,000.

''(D) For each subsequent fiscal year, the amount appropriated for the previous fiscal year, increased by the percentage increase in aggregate expenditures under this title for the fiscal year involved over the previous fiscal year.

''(4) ALLOCATION OF PAYMENTS AMONG TRUST FUNDS.—The appropriations made under paragraph (1) shall be in an allocation as reasonably reflects the proportion of such expenditures associated with part A and part B.''.

SEC. 15107. PERMITTING CARRIERS TO CARRY OUT PRIOR AUTHORIZATION FOR CERTAIN ITEMS OF DURABLE MEDICAL EQUIPMENT.

(a) IN GENERAL.—Section 1834(a)(15) (42 U.S.C. 1395m(a)(15)), as amended by section 135(b) of the Social Security Act Amendments of 1994, is amended by adding at the end the following new subparagraphs:

''(D) APPLICATION BY CARRIERS.—A carrier may develop (and periodically update) a list of items under subparagraph (A) and a list of suppliers under subparagraph (B) in the same manner as the Secretary may develop (and periodically update) such lists.

''(E) WAIVER OF PUBLICATION REQUIREMENT.—A carrier may make an advance determination under subparagraph (C) with respect to an item or supplier on a list developed by the Secretary or the carrier without regard to whether or not the Secretary has promulgated a regulation with respect to the list, except that the carrier may not make such an advance determination with respect to an item or supplier on a list until the expiration of the 30-day period beginning on the date the Secretary or the carrier places the item or supplier on the list.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of the Social Security Act Amendments of 1994.

SEC. 15108. NATIONAL HEALTH CARE ANTI-FRAUD TASK FORCE.

(a) ESTABLISHMENT.—The Attorney General, in consultation with the Secretary of Health and Human Services, shall establish a national health care anti-fraud task force (in this section referred to as the ''task force''). The Attorney General shall establish the task force within 120 days after the date of the enactment of this Act.

(b) COMPOSITION.—The task force shall include representatives of Federal agencies involved in the investigation and prosecution of persons violating laws relating to health care fraud and abuse, including at least one representative from each of the following agencies:

(1) The Department of Justice and the Federal Bureau of Investigation.

(2) The Department of Health and Human Services and the Office of the Inspector General within the Department.

(3) The office in the Department of Defense responsible for administration of the CHAMPUS program.

(4) The Department of Veterans' Affairs.

(5) The United States Postal Inspection Service.

(6) The Internal Revenue Service.

The Attorney General (or the designee of the Attorney General) shall serve as chair of the task force.

(c) DUTIES.—The task force shall coordinate Federal law enforcement activities relating to health care fraud and abuse in order to better control fraud and abuse in the delivery of health care in the United States. Specifically, the task force shall coordinate activities—

(1) in order to assure the effective targeting and investigation of persons who organize, direct, finance, or otherwise knowingly engage in health care fraud, and

(2) in order to assure full and effective cooperation between Federal and State agencies involved in health care fraud investigations.

(d) STAFF.—Each member of the task force who represents an agency shall be responsible for providing for the detail (from the agency) of at least one full-time staff person to staff the task force. Such detail shall be without change in salary, compensation, benefits, and other employment-related matters.

SEC. 15109. STUDY OF ADEQUACY OF PRIVATE QUALITY ASSURANCE PROGRAMS.

(a) IN GENERAL.—The Administrator of the Health Care Financing Administration (acting through the Director of the Office of Research and Demonstrations) shall enter into an agreement with a private entity to conduct a study during the 5-year period beginning on the date of the enactment of this Act of the adequacy of the quality assurance programs and consumer protections used by the MedicarePlus program under part C of title XVIII of the Social Security Act (as inserted by section 15002(a)), and shall include in the study an analysis of the effectiveness of such

programs in protecting plan enrollees against the risk of insufficient provision of benefits which may result from utilization controls.

(b) REPORT.—Not later than 6 months after the conclusion of the 5-year period described in subsection (a), the Administrator shall submit a report to Congress on the study conducted under subsection (a).

SEC. 15110. PENALTY FOR FALSE CERTIFICATION FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1128A(b) (42 U.S.C. 1320a–7a(b)) is amended by adding at the end the following new paragraph:

''(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

''(i) $5,000, or

''(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification.

''(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home health services furnished to the individual.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to certifications made on or after the date of the enactment of this Act.

SEC. 15111. PILOT PROJECTS.

The Secretary of Health and Human Services shall establish and operate 5 pilot projects (in various geographic regions of the United States) under which the Secretary shall implement innovative approaches to monitor payment claims under the medicare program to detect those claims that are wasteful or fraudulent.

PART 2—CRIMINAL LAW PROVISIONS

SEC. 15121. OFFENSES INVOLVING FRAUD, FALSE STATEMENT, THEFT, OR EMBEZZLEMENT.

(a) IN GENERAL.—Part A of title XI is amended by inserting after section 1128B the following:

''OFFENSES INVOLVING FRAUD, FALSE STATEMENT, THEFT, OR EMBEZZLEMENT

''SEC. 1128C. (a) FRAUD.—Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—

''(1) to defraud any person or entity in connection with the delivery of or payment for health care benefits, items, or services under a program under title XVIII or a State health care program (as defined in section 1128(h)), or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any person or entity in connection with the delivery of or payment for health care benefits, items, or services under a program under title XVIII or a State health care program,

shall be fined under title 18, United States Code, or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365(g)(3) of title 18, United States Code), such person may be imprisoned for any term of years.

''(b) FALSE STATEMENTS.—Whoever, in connection with the delivery of or payment for health care benefits, items, or services under a program under title XVIII or a State health care program, knowingly and willfully—

''(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact,

''(2) as to any material fact, makes any false, fictitious, or fraudulent statements or representations, or

''(3) makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry that is material,

shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both.

''(c) THEFT OR EMBEZZLEMENT.—Whoever willfully embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of under the custody or control of any person or entity in connection with the delivery of or payment for health care benefits, items, or services under program under title XVIII or a State health care program, shall be fined under title 18, United States Code, or imprisoned not more than 10 years, or both.''.

(b) CONFORMING AMENDMENT.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by striking ''and 1128B'' and inserting '', 1128B, and 1128C''.

Subtitle C—Regulatory Relief

PART 1—PHYSICIAN OWNERSHIP REFERRAL REFORM

SEC. 15201. REPEAL OF PROHIBITIONS BASED ON COMPENSATION ARRANGEMENTS.

(a) IN GENERAL.—Section 1877(a)(2) (42 U.S.C. 1395nn(a)(2)) is amended by striking ''is—'' and all that follows through ''equity,'' and inserting the following: ''is (except as provided in subsection (c)) an ownership or investment interest in the entity through equity,''.

(b) CONFORMING AMENDMENTS.—Section 1877 (42 U.S.C. 1395nn) is amended as follows:

(1) In subsection (b)—

(A) in the heading, by striking ''TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROHIBITIONS'' and inserting ''WHERE FINANCIAL RELATIONSHIP EXISTS''; and

(B) by redesignating paragraph (4) as paragraph (7).

(2) In subsection (c)—

(A) by amending the heading to read as follows: ''EXCEPTION FOR OWNERSHIP OR INVESTMENT INTEREST IN PUBLICLY TRADED SECURITIES AND MUTUAL FUNDS''; and

(B) in the matter preceding paragraph (1), by striking ''subsection (a)(2)(A)'' and inserting ''subsection (a)(2)''.

(3) In subsection (d)—

(A) by striking the matter preceding paragraph (1);

(B) in paragraph (3), by striking ''paragraph (1)'' and inserting ''paragraph (4)''; and

(C) by redesignating paragraphs (1), (2), and (3) as paragraphs (4), (5), and (6), and by transferring and inserting such paragraphs after paragraph (3) of subsection (b).

(4) By striking subsection (e).

(5) In subsection (f)(2)—

(A) in the matter preceding paragraph (1), by striking ''ownership, investment, and compensation'' and inserting ''ownership and investment'';

(B) in paragraph (2), by striking ''subsection (a)(2)(A)'' and all that follows through ''subsection (a)(2)(B)),'' and inserting ''subsection (a)(2),''; and

(C) in paragraph (2), by striking ''or who have such a compensation relationship with the entity''.

(6) In subsection (h)—

(A) by striking paragraphs (1), (2), and (3);

(B) in paragraph (4)(A), by striking clauses (iv) and (vi);

(C) in paragraph (4)(B), by striking ''RULES.—'' and all that follows through ''(ii) FACULTY'' and inserting ''RULES FOR FACULTY''; and

(D) by adding at the end of paragraph (4) the following new subparagraph:

''(C) MEMBER OF A GROUP.—A physician is a 'member' of a group if the physician is an owner or a bona fide employee, or both, of the group.''.

SEC. 15202. REVISION OF DESIGNATED HEALTH SERVICES SUBJECT TO PROHIBITION.

(a) IN GENERAL.—Section 1877(h)(6) (42 U.S.C. 1395nn(h)(6)) is amended by striking subparagraphs (B) through (K) and inserting the following:

''(B) Parenteral and enteral nutrients, equipment, and supplies.

''(C) Magnetic resonance imaging and computerized tomography services.

''(D) Outpatient physical or occupational therapy services.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended in the matter preceding subparagraph (A) by striking ''services'' and all that follows through ''supplies)—'' and inserting ''services—''.

(2) Section 1877(h)(5)(C) (42 U.S.C. 1395nn(h)(5)(C)) is amended—

(A) by striking '', a request by a radiologist for diagnostic radiology services, and a request by a radiation oncologist for radiation therapy,'' and inserting ''and a request by a radiologist for magnetic resonance imaging or for computerized tomography'', and

(B) by striking ''radiologist, or radiation oncologist'' and inserting ''or radiologist''.

SEC. 15203. DELAY IN IMPLEMENTATION UNTIL PROMULGATION OF REGULATIONS.

(a) IN GENERAL.—Section 13562(b) of OBRA–1993 (42 U.S.C. 1395nn note) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (3)''; and

(2) by adding at the end the following new paragraph:

''(3) PROMULGATION OF REGULATIONS.—Notwithstanding paragraphs (1) and (2), the amendments made by this section shall not apply to any referrals made before the effective date of final regulations promulgated by the Secretary of Health and Human Services to carry out such amendments.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of OBRA–1993.

SEC. 15204. EXCEPTIONS TO PROHIBITION.

(a) REVISIONS TO EXCEPTION FOR IN-OFFICE ANCILLARY SERVICES.—

(1) REPEAL OF SITE-OF-SERVICE REQUIREMENT.—Section 1877 (42 U.S.C. 1395nn) is amended—

(A) by amending subparagraph (A) of subsection (b)(2) to read as follows:

''(A) that are furnished personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are under the general supervision of the physician or of another physician in the group practice, and'', and

(B) by adding at the end of subsection (h) the following new paragraph:

''(7) GENERAL SUPERVISION.—An individual is considered to be under the 'general supervision' of a physician if the physician (or group practice of which the physician is a member) is legally responsible for the services performed by the individual and for ensuring that the individual meets licensure and certification requirements, if any, applicable under other provisions of law, regardless of whether or not the physician is physically present when the individual furnishes an item or service.''.

(2) CLARIFICATION OF TREATMENT OF PHYSICIAN OWNERS OF GROUP PRACTICE.—Section 1877(b)(2)(B) (42 U.S.C. 1395nn(b)(2)(B)) is

amended by striking ''physician or such group practice'' and inserting ''physician, such group practice, or the physician owners of such group practice''.

(3) CONFORMING AMENDMENT.—Section 1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended by amending the heading to read as follows: ''ANCILLARY SERVICES FURNISHED PERSONALLY OR THROUGH GROUP PRACTICE.—''.

(b) CLARIFICATION OF EXCEPTION FOR SERVICES FURNISHED IN A RURAL AREA.—Paragraph (5) of section 1877(b) (42 U.S.C. 1395nn(b)), as transferred by section 15201(b)(3)(C), is amended by striking ''substantially all'' and inserting ''not less than 75 percent''.

(c) REVISION OF EXCEPTION FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1877(b)(3) (42 U.S.C. 1395nn(b)(3)) is amended—

(1) in the heading by inserting ''MANAGED CARE ARRANGEMENTS'' after ''PREPAID PLANS'';

(2) in the matter preceding subparagraph (A), by striking ''organization—'' and inserting ''organization, directly or through contractual arrangements with other entities, to individuals enrolled with the organization—'';

(3) in subparagraph (A), by inserting ''or part C'' after ''section 1876'';

(4) by striking ''or'' at the end of subparagraph (C);

(5) by striking the period at the end of subparagraph (D) and inserting a comma; and

(6) by adding at the end the following new subparagraphs:

''(E) with a contract with a State to provide services under the State plan under title XIX (in accordance with section 1903(m)) or a State MediGrant plan under title XXI; or

''(F) which is a MedicarePlus organization under part C or which provides or arranges for the provision of health care items or services pursuant to a written agreement between the organization and an individual or entity if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.''.

(d) NEW EXCEPTION FOR SHARED FACILITY SERVICES.—

(1) IN GENERAL.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), is amended—

(A) by redesignating paragraphs (4) through (7) as paragraphs (5) through (8); and

(B) by inserting after paragraph (3) the following new paragraph:

''(4) SHARED FACILITY SERVICES.—In the case of a designated health service consisting of a shared facility service of a shared facility—

''(A) that is furnished—

''(i) personally by the referring physician who is a shared facility physician or personally by an individual directly employed or under the general supervision of such a physician,

''(ii) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

''(iii) to a patient of a shared facility physician; and

''(B) that is billed by the referring physician or a group practice of which the physician is a member.''.

(2) DEFINITIONS.—Section 1877(h) (42 U.S.C. 1395nn(h)), as amended by section 15201(b)(6), is amended by inserting before paragraph (4) the following new paragraph:

''(1) SHARED FACILITY RELATED DEFINITIONS.—

''(A) SHARED FACILITY SERVICE.—The term 'shared facility service' means, with respect to a shared facility, a designated health service furnished by the facility to patients of shared facility physicians.

''(B) SHARED FACILITY.—The term 'shared facility' means an entity that furnishes shared facility services under a shared facility arrangement.

''(C) SHARED FACILITY PHYSICIAN.—The term 'shared facility physician' means, with respect to a shared facility, a physician (or a group practice of which the physician is a member) who has a financial relationship under a shared facility arrangement with the facility.

''(D) SHARED FACILITY ARRANGEMENT.—The term 'shared facility arrangement' means, with respect to the provision of shared facility services in a building, a financial arrangement—

''(i) which is only between physicians who are providing services (unrelated to shared facility services) in the same building,

''(ii) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the arrangement, among the physicians in the arrangement, and

''(iii) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.''.

(e) NEW EXCEPTION FOR SERVICES FURNISHED IN COMMUNITIES WITH NO ALTERNATIVE PROVIDERS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C) and subsection (d)(1), is amended—

(1) by redesignating paragraphs (5) through (8) as paragraphs (6) through (9); and

(2) by inserting after paragraph (4) the following new paragraph:

''(5) NO ALTERNATIVE PROVIDERS IN AREA.—In the case of a designated health service furnished in any area with respect to which the Secretary determines that individuals residing in the area do not have reasonable access to such a designated health service for which subsection (a)(1) does not apply.''.

(f) NEW EXCEPTION FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), and subsection (e)(1), is amended—

(1) by redesignating paragraphs (6) through (9) as paragraphs (7) through (10); and

(2) by inserting after paragraph (5) the following new paragraph:

''(6) SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—In the case of a designated health service furnished in an ambulatory surgical center described in section 1832(a)(2)(F)(i).''.

(g) NEW EXCEPTION FOR SERVICES FURNISHED IN RENAL DIALYSIS FACILITIES.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), subsection (e)(1), and subsection (f), is amended—

(1) by redesignating paragraphs (7) through (10) as paragraphs (8) through (11); and

(2) by inserting after paragraph (6) the following new paragraph:

''(7) SERVICES FURNISHED IN RENAL DIALYSIS FACILITIES.—In the case of a designated health service furnished in a renal dialysis facility under section 1881.''.

(h) NEW EXCEPTION FOR SERVICES FURNISHED IN A HOSPICE.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), subsection (e)(1), subsection (f), and subsection (g), is amended—

(1) by redesignating paragraphs (8) through (11) as paragraphs (9) through (12); and

(2) by inserting after paragraph (7) the following new paragraph:

''(8) SERVICES FURNISHED BY A HOSPICE PROGRAM.—In the case of a designated health service furnished by a hospice program under section 1861(dd)(2).''.

(i) NEW EXCEPTION FOR SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), subsection (e)(1), subsection (f), subsection (g), and subsection (h), is amended—

(1) by redesignating paragraphs (9) through (12) as paragraphs (10) through (13); and

(2) by inserting after paragraph (8) the following new paragraph:

''(9) SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—In the case of a designated health service furnished in a comprehensive outpatient rehabilitation facility (as defined in section 1861(cc)(2)).''.

(i) DEFINITION OF REFERRAL.—Section 1877(h)(5)(A) (42 U.S.C. 1395nn(h)(5)(A)) is amended—

(1) by striking ''an item or service'' and inserting ''a designated health service'', and

(2) by striking ''the item or service'' and inserting ''the designated health service''.

SEC. 15205. REPEAL OF REPORTING REQUIREMENTS.

Section 1877 (42 U.S.C. 1395nn) is amended—

(1) by striking subsection (f); and

(2) by striking subsection (g)(5).

SEC. 15206. PREEMPTION OF STATE LAW.

Section 1877 (42 U.S.C. 1395nn) is amended by adding at the end the following new subsection:

''(i) PREEMPTION OF STATE LAW.—This section preempts State law to the extent State law is inconsistent with this section.''.

SEC. 15207. EFFECTIVE DATE.

Except as provided in section 15203(b), the amendments made by this part shall apply to referrals made on or after August 14, 1995, regardless of whether or not regulations are promulgated to carry out such amendments.

PART 2—OTHER MEDICARE REGULATORY RELIEF

SEC. 15211. REPEAL OF MEDICARE AND MEDICAID COVERAGE DATA BANK.

(a) IN GENERAL.—Section 1144 (42 U.S.C. 1320b–14) is repealed.

(c) CONFORMING AMENDMENTS.—

(1) MEDICARE.—Section 1862(b)(5) (42 U.S.C. 1395y(b)(5)) is amended—

(A) in subparagraph (B), by striking ''under—'' and all that follows through the end and inserting ''subparagraph (A) for purposes of carrying out this subsection.'', and

(B) in subparagraph (C)(i), by striking ''subparagraph (B)(i)'' and inserting ''subparagraph (B)''.

(2) MEDICAID.—Section 1902(a)(25)(A)(i) (42 U.S.C. 1396a(a)(25)(A)(i)) is amended by striking ''including the use of'' and all that follows through ''any additional measures''.

(3) ERISA.—Section 101(f) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(f)) is repealed.

(4) DATA MATCHES.—Section 552a(a)(8)(B) of title 5, United States Code, is amended—

(A) by adding ''; or'' at the end of clause (v),

(B) by striking ''or'' at the end of clause (vi), and

(C) by striking clause (vii).

SEC. 15212. CLARIFICATION OF LEVEL OF INTENT REQUIRED FOR IMPOSITION OF SANCTIONS.

(a) CLARIFICATION OF LEVEL OF KNOWLEDGE REQUIRED FOR IMPOSITION OF CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) in paragraphs (1) and (2), by inserting ''knowingly'' before ''presents'' each place it appears; and

(2) in paragraph (3), by striking ''gives'' and inserting ''knowingly gives or causes to be given''.

(2) DEFINITION OF STANDARD.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

''(6) The term 'should know' means that a person, with respect to information—

''(A) acts in deliberate ignorance of the truth or falsity of the information; or

''(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.''.

(b) CLARIFICATION OF EFFECT AND APPLICATION OF SAFE HARBOR EXCEPTIONS.—For purposes of section 1128B(b)(3) of the Social Security Act, the specification of any payment practice in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Program and Patient Protection Act of 1987 is—

(1) solely for the purpose of adding additional exceptions to the types of conduct which are not subject to an anti-kickback penalty under such section and not for the purpose of limiting the scope of such exceptions; and

(2) for the purpose of prescribing criteria for qualifying for such an exception notwithstanding the intent of the party involved.

(c) LIMITING IMPOSITION OF ANTI-KICKBACK PENALTIES TO ACTIONS WITH SIGNIFICANT PURPOSE TO INDUCE REFERRALS.—Section 1128B(b)(2) (42 U.S.C. 1320a–7b(b)(2)) is amended in the matter preceding subparagraph (A) by striking ''to induce'' and inserting ''for the significant purpose of inducing''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to acts or omissions occurring on or after January 1, 1996.

SEC. 15213. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PENALTIES FOR MANAGED CARE ARRANGEMENTS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(F) any remuneration between an organization and an individual or entity providing services pursuant to a written agreement between the organization and the individual or entity if the organization is a MedicarePlus organization under part C of title XVIII or if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to acts or omissions occurring on or after January 1, 1996.

SEC. 15214. SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.

(a) IN GENERAL.—

(1) SOLICITATIONS.—Not later than January 1, 1996, and not less than annually thereafter, the Secretary of Health and Human Services shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

(A) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987;

(B) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) of the Social Security Act and shall not serve as the basis for an exclusion under section 1128(b)(7) of such Act; and

(C) special fraud alerts to be issued pursuant to section 15101(c).

(2) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—Not later than 120 days after receiving the proposals described in subparagraphs (A) and (B) of paragraph (1), the Secretary, after considering such proposals in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(3) REPORT.—The Inspector General shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978, describe the proposals received under subparagraphs (A) and (B) of paragraph (1) and explain which proposals were included in the publication described in paragraph (2), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

(b) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under subsection (a)(2), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

(1) An increase or decrease in access to health care services.

(2) An increase or decrease in the quality of health care services.

(3) An increase or decrease in patient freedom of choice among health care providers.

(4) An increase or decrease in competition among health care providers.

(5) An increase or decrease in the cost to health care programs of the Federal Government.

(6) An increase or decrease in the potential overutilization of health care services.

(8) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in health care programs of the Federal Government.

SEC. 15215. ISSUANCE OF ADVISORY OPINIONS UNDER TITLE XI.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.), as amended by section 15104(a), is amended by inserting after section 1129 the following new section:

''ADVISORY OPINIONS

''SEC. 1130. (a) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue written advisory opinions as provided in this section.

''(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

''(1) What constitutes prohibited remuneration within the meaning of section 1128B(b).

''(2) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

''(3) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

''(4) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX or title XXI within the meaning of section 1128B(b).

''(5) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

''(c) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

''(1) Whether the fair market value shall be, or was paid or received for any goods, services or property.

''(2) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

''(d) EFFECT OF ADVISORY OPINIONS.—

''(1) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

''(2) FAILURE TO SEEK OPINION.—The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

''(e) REGULATIONS.—

''(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

''(A) the procedure to be followed by a party applying for an advisory opinion;

''(B) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

''(C) the interval in which the Secretary shall respond;

''(D) the reasonable fee to be charged to the party requesting an advisory opinion; and

''(E) the manner in which advisory opinions will be made available to the public.

''(2) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to paragraph (1)—

''(A) the Secretary shall be required to respond to a party requesting an advisory opinion by not later than 30 days after the request is received; and

''(B) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to requests for advisory opinions made on or after January 1, 1996.

SEC. 15216. PRIOR NOTICE OF CHANGES IN BILLING AND CLAIMS PROCESSING REQUIREMENTS FOR PHYSICIANS' SERVICES.

Except as may be specifically provided by Congress, the Secretary of Health and Human Services may not implement any change in the requirements imposed on the billing and processing of claims for payment for physicians' services under part B of the medicare program unless the Secretary notifies the individuals furnishing such services of the change not later than 120 days before the effective date of the change.

PART 3—PROMOTING PHYSICIAN SELF-POLICING

SEC. 15221. EXEMPTION FROM ANTITRUST LAWS FOR CERTAIN ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES.

(a) EXEMPTION DESCRIBED.—An activity relating to the provision of health care services shall be exempt from the antitrust laws, and any State law similar to the antitrust laws, if the activity is within the safe harbor described in subsection (b).

(b) SAFE HARBOR FOR ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES.—

(1) IN GENERAL.—The safe harbor referred to in subsection (a) is, subject to paragraph (2), any activity of a medical self-regulatory entity relating to standard setting or standard enforcement activities that are designed to promote the quality of health care services provided to patients.

(2) EXCEPTION.—No activity of a medical self-regulatory entity may be deemed to fall under the safe harbor established under paragraph (1) if the activity—

(A) is conducted for purposes of financial gain, or

(B) interferes with the provision of health care services by any health care provider who is not a member of the specific profession which is subject to the authority of the medical self-regulatory entity.

(c) DEFINITIONS.—For purposes of this section:

(1) ANTITRUST LAWS.—The term ''antitrust laws'' has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition.

(2) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract,

(D) a multiple employer welfare arrangement or employee benefit plan (as defined under the Employee Retirement Income Security Act of 1974), or

(E) a MedicarePlus product (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(3) HEALTH CARE SERVICE.—The term ''health care service'' means any service for which payment may be made under a health benefit plan including services related to the delivery or administration of such service.

(4) MEDICAL SELF-REGULATORY ENTITY.—The term ''medical self-regulatory entity'' means a medical society or association, a specialty board, a recognized accrediting agency, or a hospital medical staff, and includes the members, officers, employees, consultants, and volunteers or committees of such an entity.

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(6) STANDARD SETTING OR STANDARD ENFORCEMENT ACTIVITIES.— The term ''standard setting or standard enforcement activities'' means—

(A) accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs,

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters, or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee thereof) or a medical society or association for purposes of evaluating the professional conduct or quality of health care provided by a medical professional.

Subtitle D—Medical Liability Reform

PART 1—GENERAL PROVISIONS

SEC. 15301. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This subtitle shall apply with respect to any health care liability action brought in any State or Federal court, except that this subtitle shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action, or

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(b) PREEMPTION.—This subtitle shall preempt any State law to the extent such law is inconsistent with the limitations contained in this subtitle. This subtitle shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this subtitle or otherwise imposes greater restrictions than those provided in this subtitle.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this subtitle applies and which is brought under section 1332 of title 28, United States Code, the amount of noneconomic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 15302. DEFINITIONS.

As used in this subtitle:

(1) ACTUAL DAMAGES.—The term ''actual damages'' means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term ''collateral source payments'' means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term ''drug'' has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term ''economic loss'' means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term ''harm'' means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract, or

(D) a MedicarePlus product (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court against a health care provider, an entity which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or distribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(12) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) HEALTH CARE SERVICE.—The term ''health care service'' means any service for which payment may be made under a health benefit plan including services related to the delivery or administration of such service.

(14) MEDICAL DEVICE.—The term ''medical device'' has the meaning given such term in

section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(15) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(16) PERSON.—The term ''person'' means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(17) PRODUCT SELLER.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''product seller'' means a person who, in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or is otherwise involved in placing, a product in the stream of commerce, or

(ii) installs, repairs, or maintains the harm-causing aspect of a product.

(B) EXCLUSION.—Such term does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(18) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(19) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 15303. EFFECTIVE DATE.

This subtitle will apply to any health care liability action brought in a Federal or State court and to any health care liability claim subject to an alternative dispute resolution system, that is initiated on or after the date of enactment of this subtitle, except that any health care liability claim or action arising from an injury occurring prior to the date of enactment of this subtitle shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

PART 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

SEC. 15311. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 15312. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NONECONOMIC DAMAGES.—

(1) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(2) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of noneconomic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for noneconomic damages shall be several and not joint.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) PROPORTIONAL AWARDS.—The amount of punitive damages that may be awarded in any health care liability action subject to this subtitle shall not exceed 3 times the amount of damages awarded to the claimant for economic loss, or $250,000, whichever is greater. This paragraph shall be applied by the court and shall not be disclosed to the jury.

(3) APPLICABILITY.—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(4) BIFURCATION.—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(5) DRUGS AND DEVICES.—

(A) IN GENERAL.—(i) Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(ii) Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and noneconomic loss exceeds $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 15313. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, noneconomic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are identical to the provisions relating to such matters in this subtitle.

Subtitle E—Teaching Hospitals and Graduate Medical Education

PART 1—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

SEC. 15401. ESTABLISHMENT OF FUND; PAYMENTS TO TEACHING HOSPITALS.

The Social Security Act (42 U.S.C. 300 et seq.) is amended by adding after title XXI the following title:

''TITLE XXII—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

''PART A—ESTABLISHMENT OF FUND

''SEC. 2201. ESTABLISHMENT OF FUND.

''(a) IN GENERAL.—There is established in the Treasury of the United States a fund to

be known as the Teaching Hospital and Graduate Medical Education Trust Fund (in this title referred to as the 'Fund'), consisting of amounts appropriated to the Fund in subsection (d) and subsection (e)(3), amounts transferred to the Fund under section 1886(j), and such gifts and bequests as may be deposited in the Fund pursuant to subsection (f). Amounts in the Fund are available until expended.

''(b) EXPENDITURES FROM FUND.—Amounts in the Fund are available to the Secretary for making payments under section 2211.

''(c) ACCOUNTS IN FUND.—There are established within the Fund the following accounts:

''(1) The Indirect-Costs Medical Education Account.

''(2) The Medicare Direct-Costs Medical Education Account.

''(3) The General Direct-Costs Medical Education Account.

''(d) GENERAL TRANSFERS TO FUND.—

''(1) IN GENERAL.—For fiscal year 1997 and each subsequent fiscal year, there are appropriated to the Fund (effective on the applicable date under paragraph (2)), out of any money in the Treasury not otherwise appropriated, the following amounts (as applicable to the fiscal year involved):

''(A) For fiscal year 1997, $1,300,000,000.

''(B) For fiscal year 1998, $1,500,000,000.

''(C) For fiscal year 1999, $2,300,000,000.

''(D) For fiscal year 2000, $3,100,000,000.

''(E) For fiscal year 2001, $3,600,000,000.

''(F) For fiscal year 2002, $4,000,000,000.

''(G) For fiscal year 2003 and each subsequent fiscal year, the greater of the amount appropriated for the preceding fiscal year or an amount equal to the product of—

''(i) the amount appropriated for the preceding fiscal year; and

''(ii) 1 plus the percentage increase in the nominal gross domestic product for the one-year period ending upon July 1 of such preceding fiscal year.

''(2) EFFECTIVE DATE FOR ANNUAL APPROPRIATION.—For purposes of paragraph (1) (and for purposes of section 2221(a)(1), and subsections (b)(1)(A) and (c)(1)(A) of section 2231)), the applicable date for a fiscal year is the first day of the fiscal year, exclusive of Saturdays, Sundays, and Federal holidays.

''(3) ALLOCATION AMONG CERTAIN ACCOUNTS.—Of the amount appropriated in paragraph (1) for a fiscal year—

''(A) there shall be allocated to the Indirect-Costs Medical Education Account the percentage determined under paragraph (4)(B); and

''(B) there shall be allocated to the General Direct-Costs Medical Education Account the percentage determined under paragraph (4)(C).

''(4) DETERMINATION OF PERCENTAGES.—The Secretary of Health and Human Services, acting through the Administrator of the Health Care Financing Administration, shall determine the following:

''(A) The total amount of payments that were made under subsections (d)(5)(B) and (h) of section 1886 for fiscal year 1994.

''(B) The percentage of such total that was constituted by payments under subsection (d)(5)(B) of such section.

''(C) The percentage of such total that was constituted by payments under subsection (h) of such section.

''(e) INVESTMENT.—

''(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

''(2) SALE OF OBLIGATIONS.—Any obligation acquired by the Fund may be sold by the Secretary of the Treasury at the market price.

''(3) AVAILABILITY OF INCOME.—Any interest derived from obligations acquired by the Fund, and proceeds from any sale or redemption of such obligations, are hereby appropriated to the Fund.

''(f) ACCEPTANCE OF GIFTS AND BEQUESTS.—The Fund may accept on behalf of the United States money gifts and bequests made unconditionally to the Fund for the benefit of the Fund or any activity financed through the Fund.

''PART B—PAYMENTS TO TEACHING HOSPITALS

''Subpart 1—Requirement of Payments

''SEC. 2211. FORMULA PAYMENTS TO TEACHING HOSPITALS.

''(a) IN GENERAL.—Subject to subsection (d), in the case of each teaching hospital that in accordance with subsection (b) submits to the Secretary a payment document for fiscal year 1997 or any subsequent fiscal year, the Secretary shall make payments for the year to the teaching hospital for the costs of operating approved medical residency training programs. Such payments shall be made from the Fund, and the total of the payments to the hospital for the fiscal year shall equal the sum of the following:

''(1) An amount determined under section 2221 (relating to the indirect costs of graduate medical education).

''(2) An amount determined under section 2231 (relating to the direct costs of graduate medical education).

''(b) PAYMENT DOCUMENT.—For purposes of subsection (a), a payment document is a document containing such information as may be necessary for the Secretary to make payments under such subsection to a teaching hospital for a fiscal year. The document is submitted in accordance with this subsection if the document is submitted not later than the date specified by the Secretary, and the document is in such form and is made in such manner as the Secretary may require. The Secretary may require that information under this subsection be submitted to the Secretary in periodic reports.

''(c) ADMINISTRATOR OF PROGRAMS.—This part, and the subsequent parts of this title, shall be carried out by the Secretary acting through the Administrator of the Health Care Financing Administration.

''(d) SPECIAL RULES.—

''(1) AUTHORITY REGARDING PAYMENTS TO CONSORTIA OF PROVIDERS.—In the case of payments under subsection (a) that are determined under section 2231:

''(A) The requirement under such subsection to make the payments to teaching hospitals is subject to the authority of the Secretary under section 2233(a) to make payments to qualifying consortia.

''(B) If the Secretary authorizes such a consortium for purposes of section 2233(a), subsections (a) and (b) of this section apply to the consortium to the same extent and in the same manner as the subsections apply to teaching hospitals.

''(2) CERTAIN HOSPITALS.—Paragraph (1) of subsection (a) is subject to sections 2222 and 2223 of subpart 2. Paragraph (2) of subsection (a) is subject to sections 2232 through 2234 of subpart 3.

''(e) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—For purposes of this title, the term 'approved medical residency training program' has the meaning given such term in section 1886(h)(5)(A).

''Subpart 2—Amount Relating to Indirect Costs of Graduate Medical Education

''SEC. 2221. DETERMINATION OF AMOUNT RELATING TO INDIRECT COSTS.

''(a) IN GENERAL.—For purposes of section 2211(a)(1), the amount determined under this section for a teaching hospital for a fiscal year is the product of—

''(1) the amount in the Indirect-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

''(2) the percentage determined for the hospital under subsection (b).

''(b) HOSPITAL-SPECIFIC PERCENTAGE.—

''(1) IN GENERAL.—For purposes of subsection (a)(2), the percentage determined under this subsection for a teaching hospital is the mean average of the respective percentages determined under paragraph (3) for each fiscal year of the applicable period (as defined in paragraph (2)), adjusted by the Secretary (upward or downward, as the case may be) on a pro rata basis to the extent necessary to ensure that the sum of the percentages determined under this paragraph for all teaching hospitals is equal to 100 percent. The preceding sentence is subject to sections 2222 and 2223.

''(2) APPLICABLE PERIOD REGARDING RELEVANT DATA; FISCAL YEARS 1992 THROUGH 1994.—For purposes of this part, the term 'applicable period' means the period beginning on the first day of fiscal year 1992 and continuing through the end of fiscal year 1994.

''(3) RESPECTIVE DETERMINATIONS FOR FISCAL YEARS OF APPLICABLE PERIOD.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital for a fiscal year of the applicable period is the percentage constituted by the ratio of—

''(A) the total amount of payments received by the hospital under section 1886(d)(5)(B) for discharges occurring during the fiscal year involved; to

''(B) the sum of the respective amounts determined under subparagraph (A) for the fiscal year for all teaching hospitals.

''(c) AVAILABILITY OF DATA.—If a teaching hospital received the payments specified in subsection (b)(3)(A) during the applicable period but a complete set of the relevant data is not available to the Secretary for purposes of determining an amount under such subsection for the fiscal year involved, the Secretary shall for purposes of such subsection make an estimate on the basis of such data as are available to the Secretary for the applicable period.

''SEC. 2222. INDIRECT COSTS; SPECIAL RULES REGARDING DETERMINATION OF HOSPITAL-SPECIFIC PERCENTAGE.

''(a) SPECIAL RULE REGARDING FISCAL YEARS 1995 AND 1996.—

''(1) IN GENERAL.—In the case of a teaching hospital whose first payments under 1886(d)(5)(B) were for discharges occurring in fiscal year 1995 or in fiscal year 1996 (referred to in this subsection individually as a 'first payment year'), the percentage determined under paragraph (2) for the hospital is deemed to be the percentage applicable under section 2221(b) to the hospital, except that the percentage under paragraph (2) shall be adjusted in accordance with section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

''(2) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

''(A)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the total amount of payments received by the hospital under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995.

''(ii) If the first payment year for the hospital is fiscal year 1996, the amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995 if such section, as in effect for fiscal year 1996, had applied to the hospital for discharges occurring during fiscal year 1995.

''(B)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the aggregate total of the payments received by teaching hospitals under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995.

''(ii) If the first payment year for the hospital is fiscal year 1996—

''(I) the Secretary shall make an estimate in accordance with subparagraph (A)(ii) for all teaching hospitals; and

''(II) the amount determined under this subparagraph is the sum of the estimates made by the Secretary under subclause (I).

''(b) NEW TEACHING HOSPITALS.—

''(1) IN GENERAL.—Subject to paragraph (4), in the case of a teaching hospital that did not receive payments under section 1886(d)(5)(B) for any of the fiscal years 1992 through 1996, the percentage determined under paragraph (3) for the hospital is deemed to be the percentage applicable under section 2221(b) to the hospital, except that the percentage under paragraph (3) shall be adjusted in accordance with section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

''(2) DESIGNATED FISCAL YEAR REGARDING DATA.—The determination under paragraph (3) of a percentage for a teaching hospital described in paragraph (1) shall be made for the most recent fiscal year for which the Secretary has sufficient data to make the determination (referred to in this subsection as the 'designated fiscal year').

''(3) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for the teaching hospital involved is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

''(A) The amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(d)(5)(B) for the designated fiscal year if such section, as in effect for the first fiscal year for which payments pursuant to this subsection are to be made to the hospital, had applied to the hospital for the designated fiscal year.

''(B) The Secretary shall make an estimate in accordance with subparagraph (A) for all teaching hospitals. The amount determined under this subparagraph is the sum of the estimates made by the Secretary under the preceding sentence.

''(4) LIMITATION.— This subsection does not apply to a teaching hospital described in paragraph (1) if the hospital is in a State for which a demonstration project under section 1814(b)(3) is in effect.

''(c) CONSOLIDATIONS AND MERGERS.—In the case of two or more teaching hospitals that have each received payments pursuant to section 2221 for one or more fiscal years and that undergo a consolidation or merger, the percentage applicable to the resulting teaching hospital for purposes of section 2221(b) is the sum of the respective percentages that would have applied pursuant to such section if the hospitals had not undergone the consolidation or merger.

''SEC. 2223. INDIRECT COSTS; ALTERNATIVE PAYMENTS REGARDING TEACHING HOSPITALS IN CERTAIN STATES.

''(a) IN GENERAL.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section applies in lieu of section 2221. For purposes of section 2211(a)(1), the amount determined for such a teaching hospital for a fiscal year is the product of—

''(1) the amount in the Indirect-Costs Medical Education Account for the fiscal year pursuant to the allocation under section 2201(d)(3)(A) for the year; and

''(2) the percentage determined under subsection (b) for the hospital.

''(b) DETERMINATION OF PERCENTAGE.—For purposes of subsection (a)(2):

''(1) The Secretary shall make an estimate of the total amount of payments that would have been received under section 1886(d)(5)(B) by the hospital involved with respect to each of the fiscal years of the applicable period if such section (as in effect for such fiscal years) had applied to the hospital for such years.

''(2) The percentage determined under this subsection for the hospital for a fiscal year is a mean average percentage determined for the hospital in accordance with the methodology of section 2221(b)(1), except that the estimate made by the Secretary under paragraph (1) of this subsection for a fiscal year of the applicable period is deemed to be the amount that applies for purposes of section 2221(b)(3)(A) for such year.

''(c) RULE REGARDING PAYMENTS FROM CERTAIN AMOUNTS.—In the case of a teaching hospital described in subsection (a), this section does not authorize any payment to the hospital from amounts transferred to the Fund under section 1886(j).

''(d) ADJUSTMENT REGARDING PAYMENTS TO OTHER HOSPITALS.—In the case of a fiscal year for which payments pursuant to subsection (a) are made to one or more teaching hospitals, the following applies:

''(1) The Secretary shall determine a percentage equal to the sum of the respective percentages determined for the hospitals under subsection (b).

''(2) The Secretary shall determine an amount equal to the product of—

''(A) the percentage determined under paragraph (1); and

''(B) the amount in the Indirect-Costs Medical Education Account for the fiscal year pursuant to the transfer under section 1886(j)(1).

''(3) The Secretary shall, for each hospital (other than hospitals described in subsection (a)), make payments to the hospital in amounts whose sum for the fiscal year is equal to the product of—

''(A) the amount determined under paragraph (2); and

''(B) the percentage that applies to the hospital for purposes of section 2221(b), except that such percentage shall be adjusted in accordance with the methodology of section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

''Subpart 3—Amount Relating to Direct Costs of Graduate Medical Education

''SEC. 2231. DETERMINATION OF AMOUNT RELATING TO DIRECT COSTS.

''(a) IN GENERAL.—For purposes of section 2211(a)(2), the amount determined under this section for a teaching hospital for a fiscal year is the sum of—

''(1) the amount determined under subsection (b) (relating to the General Direct-Costs Medical Education Account); and

''(2) the amount determined under subsection (c) (relating to the Medicare Direct-Costs Medical Education Account).

''(b) PAYMENT FROM GENERAL ACCOUNT.—

''(1) IN GENERAL.—For purposes of subsection (a)(1), the amount determined under this subsection for a teaching hospital for a fiscal year is the product of—

''(A) the amount in the General Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

''(B) the percentage determined for the hospital under paragraph (2).

''(2) HOSPITAL-SPECIFIC PERCENTAGE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B), the percentage determined under this paragraph for a teaching hospital is the mean average of the respective percentages determined under subparagraph (B) for each fiscal year of the applicable period (as defined in section 2221(b)(2)), adjusted by the Secretary (upward or downward, as the case may be) on a pro rata basis to the extent necessary to ensure that the sum of the percentages determined under this subparagraph for all teaching hospitals is equal to 100 percent. The preceding sentence is subject to sections 2232 through 2234.

''(B) RESPECTIVE DETERMINATIONS FOR FISCAL YEARS OF APPLICABLE PERIOD.—For purposes of subparagraph (A), the percentage determined under this subparagraph for a teaching hospital for a fiscal year of the applicable period is the percentage constituted by the ratio of—

''(i) the total amount of payments received by the hospital under section 1886(h) for cost reporting periods beginning during the fiscal year involved; to

''(ii) the sum of the respective amounts determined under clause (i) for the fiscal year for all teaching hospitals.

''(3) AVAILABILITY OF DATA.—If a teaching hospital received the payments specified in paragraph (2)(B)(i) during the applicable period but a complete set of the relevant data is not available to the Secretary for purposes of determining an amount under such paragraph for the fiscal year involved, the Secretary shall for purposes of such paragraph make an estimate on the basis of such data as are available to the Secretary for the applicable period.

''(c) PAYMENT FROM MEDICARE ACCOUNT.—

''(1) IN GENERAL.—For purposes of subsection (a)(2), the amount determined under this subsection for a teaching hospital for a fiscal year is the product of—

''(A) the amount in the Medicare Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

''(B) the percentage determined for the hospital under paragraph (2) for the fiscal year.

''(2) HOSPITAL-SPECIFIC PERCENTAGE.—For purposes of paragraph (1)(B), the percentage determined under this subsection for a teaching hospital for a fiscal year is the percentage constituted by the ratio of—

''(A) the estimate made by the Secretary for the hospital for the fiscal year under section 1886(j)(2)(B); to

''(B) the sum of the respective estimates referred to in subparagraph (A) for all teaching hospitals.

''SEC. 2232. DIRECT COSTS; SPECIAL RULES REGARDING DETERMINATION OF HOSPITAL-SPECIFIC PERCENTAGE.

''(a) SPECIAL RULE REGARDING FISCAL YEARS 1995 AND 1996.—

''(1) IN GENERAL.—In the case of a teaching hospital whose first payments under 1886(h) were for cost reporting period beginning in fiscal year 1995 or in fiscal year 1996 (referred to in this subsection individually as a 'first payment year'), the percentage determined under paragraph (2) for the hospital is deemed to be the percentage applicable under section 2231(b)(2) to the hospital, except that the percentage under paragraph (2) shall be adjusted in accordance with section 2231(b)(2)(A) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

''(2) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

''(A)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the total amount of payments received by the hospital under section 1886(h) for cost reporting periods beginning in fiscal year 1995.

''(ii) If the first payment year for the hospital is fiscal year 1996, the amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(h) for cost reporting periods beginning in fiscal year 1995 if such section, as in effect for fiscal year 1996, had applied to the hospital for fiscal year 1995.

''(B)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the aggregate total of the payments received by teaching hospitals under section 1886(h) for cost reporting periods beginning in fiscal year 1995.

''(ii) If the first payment year for the hospital is fiscal year 1996—

''(I) the Secretary shall make an estimate in accordance with subparagraph (A)(ii) for all teaching hospitals; and

''(II) the amount determined under this subparagraph is the sum of the estimates made by the Secretary under subclause (I).

''(b) NEW TEACHING HOSPITALS.—

''(1) IN GENERAL.—Subject to paragraph (4), in the case of a teaching hospital that did not receive payments under section 1886(h) for any of the fiscal years 1992 through 1996, the percentage determined under paragraph (3) for the hospital is deemed to be the percentage applicable under section 2231(b)(2) to the hospital, except that the percentage under paragraph (3) shall be adjusted in accordance with section 2231(b)(2)(A) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

''(2) DESIGNATED FISCAL YEAR REGARDING DATA.—The determination under paragraph (3) of a percentage for a teaching hospital described in paragraph (1) shall be made for the most recent fiscal year for which the Secretary has sufficient data to make the determination (referred to in this subsection as the 'designated fiscal year').

''(3) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for the teaching hospital involved is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

''(A) The amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(h) for the designated fiscal year if such section, as in effect for the first fiscal year for which payments pursuant to this subsection are to be made to the hospital, had applied to the hospital for cost reporting periods beginning in the designated fiscal year.

''(B) The Secretary shall make an estimate in accordance with subparagraph (A) for all teaching hospitals. The amount determined under this subparagraph is the sum of the estimates made by the Secretary under the preceding sentence.

''(4) LIMITATION.— This subsection does not apply to a teaching hospital described in paragraph (1) if the hospital is in a State for which a demonstration project under section 1814(b)(3) is in effect.

''(c) CONSOLIDATIONS AND MERGERS.—In the case of two or more teaching hospitals that have each received payments pursuant to section 2231 for one or more fiscal years and that undergo a consolidation or merger, the percentage applicable to the resulting teaching hospital for purposes of section 2231(b) is the sum of the respective percentages that would have applied pursuant to such section if the hospitals had not undergone the consolidation or merger.

''SEC. 2233. DIRECT COSTS; AUTHORITY FOR PAYMENTS TO CONSORTIA OF PROVIDERS.

''(a) IN GENERAL.—In lieu of making payments to teaching hospitals pursuant to section 2231, the Secretary may make payments under this section to consortia that meet the requirements of subsection (b).

''(b) QUALIFYING CONSORTIUM.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

''(1) The consortium consists of an approved medical residency training program and one or more of the following entities:

''(A) Schools of allopathic medicine or osteopathic medicine.

''(B) Teaching hospitals.

''(C) Other approved medical residency training programs.

''(D) Federally qualified health centers.

''(E) Medical group practices.

''(F) Managed care entities.

''(G) Entities furnishing outpatient services.

''(H) Such other entities as the Secretary determines to be appropriate.

''(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

''(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

''(4) The consortium meets such additional requirements as the Secretary may establish.

''(c) PAYMENTS FROM ACCOUNTS.—

''(1) IN GENERAL.—Subject to subsection (d), the total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall be the sum of—

''(1) the aggregate amount determined for the teaching hospitals of the consortium pursuant to paragraph (1) of section 2231(a); and

''(2) an amount determined in accordance with the methodology that applies pursuant to paragraph (2) of such section, except that the estimate used for purposes of subsection (c)(2)(A) of such section shall be the estimate made for the consortium under section 1886(j)(2)(C)(ii).

''(d) LIMITATION ON AGGREGATE TOTAL OF PAYMENTS TO CONSORTIA.—The aggregate total of the amounts paid under subsection (c)(2) to qualifying consortia for a fiscal year may not exceed the sum of—

''(1) the aggregate total of the amounts that would have been paid under section 2231(c) for the fiscal year to the teaching hospitals of the consortia if the hospitals had not been participants in the consortia; and

''(2) an amount equal to 1 percent of the amount that applies under section 2231(c)(1)(A) for the fiscal year (relating to the Medicare Direct-Costs Medical Education Account).

''(e) DEFINITION.—For purposes of this title, the term 'qualifying consortium' means a consortium that meets the requirements of subsection (b).

''SEC. 2234. DIRECT COSTS; ALTERNATIVE PAYMENTS REGARDING TEACHING HOSPITALS IN CERTAIN STATES.

''(a) IN GENERAL.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section applies in lieu of section 2231. For purposes of section 2211(a)(2), the amount determined for a teaching hospital for a fiscal year is the product of—

''(1) the amount in the General Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

''(2) the percentage determined under subsection (b) for the hospital.

''(b) DETERMINATION OF PERCENTAGE.—For purposes of subsection (a)(2):

''(1) The Secretary shall make an estimate of the total amount of payments that would have been received under section 1886(h) by the hospital involved with respect to each of the fiscal years of the applicable period if such section (as in effect for such fiscal years) had applied to the hospital for such years.

''(2) The percentage determined under this subsection for the hospital for a fiscal year is a mean average percentage determined for the hospital in accordance with the methodology of section 2231(b)(2)(A), except that the estimate made by the Secretary under paragraph (1) of this subsection for a fiscal year of the applicable period is deemed to be the amount that applies for purposes of section 2231(b)(2)(B)(i) for such year.

''(c) RULE REGARDING PAYMENTS FROM CERTAIN AMOUNTS.—In the case of a teaching hospital described in subsection (a), this section does not authorize any payment to the hospital from amounts transferred to the Fund under section 1886(j).

''Subpart 4—General Provisions

''SEC. 2241. ADJUSTMENTS IN PAYMENT AMOUNTS.

''(a) COLLECTION OF DATA ON ACCURACY OF ESTIMATES.—The Secretary shall collect data on whether the estimates made by the Secretary under section 1886(j) for a fiscal year were substantially accurate.

''(b) ADJUSTMENTS.—If the Secretary determines under subsection (a) that an estimate for a fiscal year was not substantially accurate, the Secretary shall, for the first fiscal year beginning after the Secretary makes the determination—

''(1) make adjustments accordingly in transfers to the Fund under section 1886(j); and

''(2) make adjustments accordingly in the amount of payments to teaching hospitals pursuant to 2231(c) (or, as applicable, to qualifying consortia pursuant to section 2233(c)(2)).''.

PART 2—AMENDMENTS TO MEDICARE PROGRAM

SEC. 15411. TRANSFERS TO TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.

Section 1886 (42 U.S.C. 1395ww) is amended—

(1) in subsection (d)(5)(B), in the matter preceding clause (i), by striking ''The Secretary shall provide'' and inserting the following: ''For discharges occurring on or before September 30, 1996, the Secretary shall provide'';

(2) in subsection (h)—

(A) in paragraph (1), in the first sentence, by striking ''the Secretary shall provide'' and inserting ''the Secretary shall, subject to paragraph (6), provide''; and

(B) by adding at the end the following paragraph:

''(6) LIMITATION.—

''(A) IN GENERAL.—The authority to make payments under this subsection applies only with respect to cost reporting periods ending on or before September 30, 1996, except as provided in subparagraph (B).

''(B) RULE REGARDING PORTION OF LAST COST REPORTING PERIOD.—In the case of a cost reporting period that extends beyond September 30, 1996, payments under this subsection shall be made with respect to such portion of the period as has lapsed as of such date.

''(C) RULE OF CONSTRUCTION.—This paragraph may not be construed as authorizing any payment under section 1861(v) with respect to graduate medical education.''; and

(3) by adding at the end the following subsection:

''(j) TRANSFERS TO TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.—

''(1) INDIRECT COSTS OF MEDICAL EDUCATION.—

''(A) IN GENERAL.—From the Federal Hospital Insurance Trust Fund, the Secretary shall, for fiscal year 1997 and each subsequent fiscal year, transfer to the Indirect-Costs Medical Education Account (under section 2201) an amount determined by the Secretary in accordance with subparagraph (B).

''(B) DETERMINATION OF AMOUNTS.—The Secretary shall make an estimate for the fiscal year involved of the nationwide total of the amounts that would have been paid under subsection (d)(5)(B) to hospitals during the fiscal year if such payments had not been terminated for discharges occurring after September 30, 1996. For purposes of subparagraph (A), the amount determined under this subparagraph for the fiscal year is the estimate made by the Secretary under the preceding sentence.

''(2) DIRECT COSTS OF MEDICAL EDUCATION.—

''(A) IN GENERAL.—From the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the Secretary shall, for fiscal year 1997 and each subsequent fiscal year, transfer to the Medicare Direct-Costs Medical Education Account (under section 2201) the sum of—

''(i) an amount determined by the Secretary in accordance with subparagraph (B); and

''(ii) as applicable, an amount determined by the Secretary in accordance with subparagraph (C)(ii).

''(B) DETERMINATION OF AMOUNTS.—For each hospital (other than a hospital that is a member of a qualifying consortium referred to in subparagraph (C)), the Secretary shall make an estimate for the fiscal year involved of the amount that would have been paid under subsection (h) to the hospital during the fiscal year if such payments had not been terminated for cost reporting periods ending on or before September 30, 1996. For purposes of subparagraph (A)(i), the amount determined under this subparagraph for the fiscal year is the sum of all estimates made by the Secretary under the preceding sentence.

''(C) ESTIMATES REGARDING QUALIFYING CONSORTIA.—If the Secretary elects to authorize one or more qualifying consortia for purposes of section 2233(a), the Secretary shall carry out the following:

''(i) The Secretary shall establish a methodology for making payments to qualifying consortia with respect to the reasonable direct costs of such consortia in carrying out programs of graduate medical education. The methodology shall be the methodology established in subsection (h), modified to the extent necessary to take into account the participation in such programs of entities other than hospitals.

''(ii) For each qualifying consortium, the Secretary shall make an estimate for the fiscal year involved of the amount that would have been paid to the consortium during the fiscal year if, using the methodology under clause (i), payments had been made to the consortium for the fiscal year as reimbursements with respect to cost reporting periods. For purposes of subparagraph (A)(ii), the amount determined under this clause for the fiscal year is the sum of all estimates made by the Secretary under the preceding sentence.

''(D) ALLOCATION BETWEEN FUNDS.—In providing for a transfer under subparagraph (A) for a fiscal year, the Secretary shall provide for an allocation of the amounts involved between part A and part B (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

''(3) APPLICABILITY OF CERTAIN AMENDMENTS.—Amendments made to subsection (d)(5)(B) and subsection (h) that are effective on or after October 1, 1996, apply only for purposes of estimates under paragraphs (1) and (2) and for purposes of determining the amount of payments under 2211. Such amendments do not require any adjustment to amounts paid under subsection (d)(5)(B) or (h) with respect to fiscal year 1996 or any prior fiscal year.

''(4) RELATIONSHIP TO CERTAIN DEMONSTRATION PROJECTS.—In the case of a State for which a demonstration project under section 1814(b)(3) is in effect, the Secretary, in making determinations of the rates of increase under such section, shall include all amounts transferred under this subsection. Such amounts shall be so included to the same extent and in the same manner as amounts determined under subsections (d)(5)(B) and (h) were included in such determination under the provisions of this title in effect on September 30, 1996.''.

SEC. 15412. MODIFICATION IN PAYMENT POLICIES REGARDING GRADUATE MEDICAL EDUCATION.

(a) INDIRECT COSTS OF MEDICAL EDUCATION; APPLICABLE PERCENTAGE.—

(1) MODIFICATION REGARDING 5.6 PERCENT.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(A) by striking ''on or after October 1, 1988,'' and inserting ''on or after October 1, 1999,''; and

(B) by striking ''1.89'' and inserting ''1.38''.

(2) SPECIAL RULE REGARDING FISCAL YEARS 1996 THROUGH 1998; MODIFICATION REGARDING 6 PERCENT .—Section 1886(d)(5)(B)(ii), as amended by paragraph (1), is amended by adding at the end the following: ''In the case of discharges occurring on or after October 1, 1995, and before October 1, 1999, the preceding sentence applies to the same extent and in the same manner as the sentence applies to discharges occurring on or after October 1, 1999, except that the term '1.38' is deemed to be '1.48'.''.

(3) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNTS.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking ''1985'' and inserting the following: ''1985, but (for discharges occurring after September 30, 1995) not taking into account any reductions in such costs resulting from the amendments made by section 15412(a) of the Medicare Preservation Act of 1995''.

(b) DIRECT COSTS OF MEDICAL EDUCATION.—

(1) LIMITATION ON NUMBER OF FULL-TIME-EQUIVALENT RESIDENTS.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—

''(i) IN GENERAL.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1995, and on or before September 30, 2002, the number of full-time-equivalent residents determined under this paragraph with respect to an approved medical residency training program may not exceed the number of full-time-equivalent residents with respect to the program as of August 1, 1995 (except that this subparagraph applies only to approved medical residency training programs in the fields of allopathic medicine and osteopathic medicine).

''(ii) DISPOSITION OF UNUSED RESIDENCY POSITIONS.—In the case of a cost reporting period to which the limitation under clause (i) applies, if for such a period the number of full-time-equivalent residents determined under this paragraph with respect to an approved medical residency training program is less than the maximum number applicable to the program under such clause, the Secretary may authorize for one or more other approved medical residency training programs offsetting increases in the respective maximum numbers that otherwise would be applicable under such clause to the programs. In authorizing such increases with respect to a cost reporting period, the Secretary shall ensure that the national total of the respective maximum numbers determined under such clause with respect to approved medical residency training programs is not exceeded.''.

(2) EXCLUSION OF RESIDENTS AFTER INITIAL RESIDENCY PERIOD.—Section 1886(h)(4)(C) (42 U.S.C. 1395ww(h)(4)(C)) is amended to read as follows:

''(C) WEIGHTING FACTORS FOR RESIDENTS.—Effective for cost reporting periods beginning on or after October 1, 1997, such rules shall provide that, in the calculation of the number of full-time-equivalent residents in an approved residency program, the weighting factor for a resident who is in the initial residency period (as defined in paragraph (5)(F)) is 1.0 and the weighting factor for a resident who has completed such period is 0.0. (In the case of cost reporting periods beginning before October 1, 1997, the weighting factors that apply in such calculation are the weighting factors that were applicable under this subparagraph on the day before the date of the enactment of the Medicare Preservation Act of 1995.)''.

(3) REDUCTIONS IN PAYMENTS FOR ALIEN RESIDENTS.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)), as amended by paragraph (1), is amended by adding at the end the following new subparagraph:

''(G) SPECIAL RULES FOR ALIEN RESIDENTS.—In the case of individuals who are not citizens or nationals of the United States, aliens lawfully admitted to the United States for permanent residence, aliens admitted to the United States as refugees, or citizens of Canada, in the calculation of the number of full-time-equivalent residents in an approved medical residency program, the following rules shall apply with respect to such individuals who are residents in the program:

''(i) For a cost reporting period beginning during fiscal year 1996, for each such individual the Secretary shall apply a weighting factor of .75.

''(ii) For a cost reporting period beginning during fiscal year 1997, for each such individual the Secretary shall apply a weighting factor of .50.

''(iii) For a cost reporting period beginning during fiscal year 1998 or any subsequent fiscal year, for each such individual the Secretary shall apply a weighting factor of .25.''.

(4) EFFECTIVE DATE.—Except as provided otherwise in this subsection (or in the amendments made by this subsection), the amendments made by this subsection apply to hospital cost reporting periods beginning on or after October 1, 1995.

PART 3—REFORM OF FEDERAL POLICIES REGARDING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION

SEC. 15421. ESTABLISHMENT OF ADVISORY PANEL FOR RECOMMENDING POLICIES.

Title XXII of the Social Security Act, as added by section 15401, is amended by adding at the end the following part:

''PART C—OTHER MATTERS

''SEC. 2251. ADVISORY PANEL ON REFORM IN FINANCING OF TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION.

''(a) ESTABLISHMENT.—The Chair of the Medicare Payment Review Commission under section 1806 shall establish a temporary advisory panel to be known as the Advisory Panel on Financing for Teaching Hospitals and Graduate Medical Education (in this section referred to as the 'Panel').

''(b) DUTIES.—The Panel shall develop recommendations on whether and to what extent Federal policies regarding teaching hospitals and graduate medical education should be reformed, including recommendations regarding the following:

''(1) The financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education.

''(2) The financing of teaching hospitals, including consideration of the difficulties encountered by such hospitals as competition among health care entities increases. Matters considered under this paragraph shall include consideration of the effects on teaching hospitals of the method of financing used for the MedicarePlus program under part C of title XVIII.

''(3) The methodology for making payments for graduate medical education, and the selection of entities to receive the payments. Matters considered under this paragraph shall include the following:

''(A) The methodology under part B for making payments from the Fund, including the use of data from the fiscal years 1992 through 1994, and including the methodology that applies with respect to consolidations and mergers of participants in the program under such part and with respect to the inclusion of additional participants in the program.

''(B) Issues regarding children's hospitals, and approved medical residency training programs in pediatrics.

''(C) Whether and to what extent payments are being made (or should be made) for graduate training in the various nonphysician health professions.

''(4) Federal policies regarding international medical graduates.

''(5) The dependence of schools of medicine on service-generated income.

''(6) The effects of the amendments made by section 15412 of the Medicare Preservation Act of 1995, including adverse effects on teaching hospitals that result from modifications in policies regarding international medical graduates.

''(7) Whether and to what extent the needs of the United States regarding the supply of physicians will change during the 10-year beginning on October 1, 1995, and whether and to what extent any such changes will have significant financial effects on teaching hospitals.

''(8) The appropriate number and mix of residents.

''(c) COMPOSITION.—Not later than three months after being designated as the initial chair of the Medicare Payment Review Commission, the Chair of the Commission shall appoint to the Panel 19 individuals who are not members of the Commission, who are not officers or employees of the United States, and who possess expertise on matters on which the Panel is to make recommendations under subsection (b). Such individuals shall include the following:

''(1) Deans from allopathic and osteopathic schools of medicine.

''(2) Chief executive officers (or equivalent administrative heads) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs.

''(3) Chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery.

''(4) Individuals with leadership experience from each of the fields of advanced practice nursing, physician assistants, and podiatric medicine.

''(5) Individuals with substantial experience in the study of issues regarding the composition of the health care workforce of the United States.

''(6) Individuals with expertise on the financing of health care.

''(7) Representatives from health insurance organizations and health plan organizations.

''(d) RELATIONSHIP OF PANEL TO MEDICARE PAYMENT REVIEW COMMISSION.—From amounts appropriated under subsection (n), the Medicare Payment Review Commission shall provide for the Panel such staff and administrative support (including quarters for the Panel) as may be necessary for the Panel to carry out the duties under subsection (b).

''(e) CHAIR.—The Panel shall designate a member of the Panel to serve as the Chair of the Panel.

''(f) MEETINGS.—The Panel shall meet at the call of the Chair or a majority of the members, except that the first meeting of the Panel shall be held not later than three months after the date on which appointments under subsection (c) are completed.

''(g) TERMS.—The term of a member of the Panel is the duration of the Panel.

''(h) VACANCIES.—

''(1) IN GENERAL.—A vacancy in the membership of the Panel does not affect the power of the remaining members to carry out the duties under subsection (b). A vacancy in the membership of the Panel shall be filled in the manner in which the original appointment was made.

''(2) INCOMPLETE TERM.—If a member of the Panel does not serve the full term applicable to the member, the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

''(i) COMPENSATION; REIMBURSEMENT OF EXPENSES.—

''(1) COMPENSATION.—Members of the Panel shall receive compensation for each day (including traveltime) engaged in carrying out the duties of the Committee. Such compensation may not be in an amount in excess of the daily equivalent of the annual maximum rate of basic pay payable under the General Schedule (under title 5, United States Code) for positions above GS–15.

''(2) REIMBURSEMENT.—Members of the Panel may, in accordance with chapter 57 of title 5, United States Code, be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Panel.

''(j) CONSULTANTS.—The Panel may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Panel may determine to be useful in carrying out the duties under subsection (b). The Panel may not procure services under this subsection at any rate in excess of the daily equivalent of the maximum annual rate of basic pay payable under the General Schedule for positions above GS–15. Consultants under this subsection may, in accordance with chapter 57 of title 5, United States Code, be reimbursed for travel, subsistence, and other necessary expenses incurred for activities carried out on behalf of the Panel pursuant to subsection (b).

''(k) POWERS.—

''(1) IN GENERAL.—For the purpose of carrying out the duties of the Panel under subsection (b), the Panel may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Panel considers appropriate.

''(2) OBTAINING OFFICIAL INFORMATION.—Upon the request of the Panel, the heads of Federal agencies shall furnish directly to the Panel information necessary for the Panel to carry out the duties under subsection (b).±

''(3) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies.

''(l) REPORTS.—

''(1) FIRST INTERIM REPORT.—Not later than one year after the date of the enactment of the Medicare Preservation Act of 1995, the Panel shall submit to the Congress a report providing the recommendations of the Panel regarding the matters specified in paragraphs (1) through (4) of subsection (b).

''(2) SECOND INTERIM REPORT.—Not later than 2 years after the date of enactment specified in paragraph (1), the Panel shall submit to the Congress a report providing the recommendations of the Panel regarding the matters specified in paragraphs (5) and (6) of subsection (b).

''(3) FINAL REPORT.—Not later than 3 years after the date of enactment specified in paragraph (1), the Panel shall submit to the Congress a final report providing the recommendations of the Panel under subsection (b).

''(m) DURATION.—The Panel terminates upon the expiration of the 180-day period beginning on the date on which the final report under subsection (l)(3) is submitted to the Congress.

''(n) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—Subject to paragraph (2), for the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1996 through 1999.

''(2) LIMITATION.—The authorization of appropriations established in paragraph (1) is effective only with respect to appropriations made from allocations under section 302(b) of the Congressional Budget Act of 1974—

''(A) for the Subcommittee on Labor, Health and Human Services, and Education, Committee on Appropriations of the House of Representatives, in the case of any bill, resolution, or amendment considered in the House; and

''(B) for the Subcommittee on Labor, Health and Human Services, and Education, Committee on Appropriations of the Senate, in the case of any bill, resolution, or amendment considered in the Senate.''.

Subtitle F—Provisions Relating to Medicare Part A

PART 1—HOSPITALS

Subpart A—General Provisions Relating to Hospitals

SEC. 15501. REDUCTIONS IN INFLATION UPDATES FOR PPS HOSPITALS.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended by striking subclauses (XI), (XII), and (XIII) and inserting the following:

''(XI) for fiscal year 1996, the market basket percentage increase minus 2.5 percentage points for hospitals in all areas,

''(XII) for each of the fiscal years 1997 through 2002, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas, and

''(XIII) for fiscal year 2003 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.''.

SEC. 15502. REDUCTIONS IN DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking ''The amount'' and inserting ''Subject to clause (ix), the amount''; and

(2) by adding at the end the following new clause:

''(ix) In the case of discharges occurring on or after October 1, 1995, the additional payment amount otherwise determined under clause (ii) shall be reduced as follows:

''(I) For discharges occurring on or after October 1, 1995, and on or before September 30, 1996, by 20 percent.

''(II) For discharges occurring on or after October 1, 1996, and on or before September 30, 1997, by 25 percent.

''(III) For discharges occurring on or after October 1, 1997, by 30 percent.''.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNTS.—Section 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)) is amended by striking the period at the end and inserting the following: '', and the Secretary shall not take into account any reductions in the amount of such additional payments resulting from the amendments made by section 15502(a) of the Medicare Preservation Act of 1995.''.

SEC. 15503. PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.

(a) REDUCTION IN PAYMENTS FOR PPS HOSPITALS.—

(1) CONTINUATION OF CURRENT REDUCTIONS.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended in the second sentence—

(A) by striking ''through 1995'' and inserting ''through 2002''; and

(B) by inserting after ''10 percent reduction'' the following: ''(or a 15 percent reduction in the case of payments during fiscal years 1996 through 2002)''.

(2) REDUCTION IN BASE PAYMENT RATES.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: ''In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.47 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Medicare Preservation Act of 1995) and shall reduce by 8.27 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on such date of enactment).''.

(b) REDUCTION IN PAYMENTS FOR PPS-EXEMPT HOSPITALS.—Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

''(4)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services furnished during fiscal years 1996 through 2002 of a hospital which is not a subsection (d) hospital or a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent.

''(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1861(mm)(1)).''.

(c) HOSPITAL-SPECIFIC ADJUSTMENT FOR CAPITAL-RELATED TAX COSTS.—Section 1886(g)(1) (42 U.S.C. 1395ww(g)(1)) is amended—

(1) by redesignating subparagraph (C) as subparagraph (D), and

(2) by inserting after subparagraph (B) the following:

''(C)(i) For discharges occurring after September 30, 1995, such system shall provide for an adjustment in an amount equal to the amount determined under clause (iv) for capital-related tax costs for each hospital that is eligible for such adjustment.

''(ii) Subject to clause (iii), a hospital is eligible for an adjustment under this subparagraph, with respect to discharges occurring in a fiscal year, if the hospital—

''(I) is a hospital that may otherwise receive payments under this subsection,

''(II) is not a public hospital, and

''(III) incurs capital-related tax costs for the fiscal year.

''(iii)(I) In the case of a hospital that first incurs capital-related tax costs in a fiscal year after fiscal year 1992 because of a change from nonproprietary to proprietary status or because the hospital commenced operation after such fiscal year, the first fiscal year for which the hospital shall be eligible for such adjustment is the second full fiscal year following the fiscal year in which the hospital first incurs such costs.

''(II) In the case of a hospital that first incurs capital-related tax costs in a fiscal year after fiscal year 1992 because of a change in State or local tax laws, the first fiscal year for which the hospital shall be eligible for such adjustment is the fourth full fiscal year following the fiscal year in which the hospital first incurs such costs.

''(iv) The per discharge adjustment under this clause shall be equal to the hospital-specific capital-related tax costs per discharge of a hospital for fiscal year 1992 (or, in the case of a hospital that first incurs capital-related tax costs for a fiscal year after fiscal year 1992, for the first full fiscal year for which such costs are incurred), updated to the fiscal year to which the adjustment applies. Such per discharge adjustment shall be added to the Federal capital rate, after such rate has been adjusted as described in 42 CFR 412.312 (as in effect on the date of the enactment of the Medicare Preservation Act of 1995), and before such rate is multiplied by the applicable Federal rate percentage.

''(v) For purposes of this subparagraph, capital-related tax costs include—

''(I) the costs of taxes on land and depreciable assets owned by a hospital (or related organization) and used for patient care,

''(II) payments in lieu of such taxes (made by hospitals that are exempt from taxation), and

''(III) the costs of taxes paid by a hospital (or related organization) as lessee of land, buildings, or fixed equipment from a lessor that is unrelated to the hospital (or related organization) under the terms of a lease that requires the lessee to pay all expenses (including mortgage, interest, and amortization) and leaves the lessor with an amount free of all claims (sometimes referred to as a 'net net net' or 'triple net' lease).

In determining the adjustment required under clause (i), the Secretary shall not take into account any capital-related tax costs of a hospital to the extent that such costs are based on tax rates and assessments that exceed those for similar commercial properties.

''(vi) The system shall provide that the Federal capital rate for any fiscal year after September 30, 1995, shall be reduced by a percentage sufficient to ensure that the adjustments required to be paid under clause (i) for a fiscal year neither increase nor decrease the total amount that would have been paid under this system but for the payment of such adjustments for such fiscal year.''.

(d) REVISION OF EXCEPTIONS PROCESS UNDER PROSPECTIVE PAYMENT SYSTEM FOR CERTAIN PROJECTS.—

(1) IN GENERAL.—Section 1886(g)(1) (42 U.S.C. 1395ww(g)(1)), as amended by subsection (c), is amended—

(1) by redesignating subparagraph (D) as subparagraph (E), and

(2) by inserting after subparagraph (C) the following:

''(D) The exceptions under the system provided by the Secretary under subparagraph (B)(iii) shall include the provision of exception payments under the special exceptions process provided under 42 CFR 412.348(g) (as in effect on September 1, 1995), except that the Secretary shall revise such process as follows:

''(i) A hospital with at least 100 beds which is located in an urban area shall be eligible under such process without regard to its disproportionate patient percentage under subsection (d)(5)(F) or whether it qualifies for additional payment amounts under such subsection.

''(ii) The minimum payment level for qualifying hospitals shall be 85 percent.

''(iii) A hospital shall be considered to meet the requirement that it completes the project involved no later than the end of the hospital's last cost reporting period beginning after October 1, 2001, if—

''(I) the hospital has obtained a certificate of need for the project approved by the State or a local planning authority, and

''(II) by September 1, 1995, the hospital has expended on the project at least $750,000 or 10 percent of the estimated cost of the project.

''(iv) The amount of the exception payment made shall not be reduced by any offsetting amounts.''.

(2) CONFORMING AMENDMENT.—Section 1886(g)(1)(B)(iii) (42 U.S.C. 1395ww(g)(1)(B)(iii)) is amended by striking ''may provide'' and inserting ''shall provide (in accordance with subparagraph (D))''.

SEC. 15504. REDUCTION IN ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION.

For provisions modifying medicare payment policies regarding graduate medical education, see part 2 of subtitle E.

SEC. 15505. TREATMENT OF PPS-EXEMPT HOSPITALS.

(a) UPDATES.—Section 1886(b)(3)(B)(ii)(V) (42 U.S.C. 1395ww(b)(3)(B)(ii)(V)) is amended by striking ''thorugh 1997'' and inserting ''through 2002''.

(b) REBASING FOR CERTAIN LONG-TERM CARE HOSPITALS.—

(1) IN GENERAL.—Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)) is amended—

(A) in subparagraph (A), by striking ''and (E)'' and inserting ''(E), and (F)'';

(B) in subparagraph (B)(ii), by striking ''(A) and (E)'' and inserting ''(A), (E), and (F)''; and

(C) by adding at the end the following new subparagraph:

''(F)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)), the term 'target amount' means—

''(I) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1991; or

''(II) with respect to a later cost reporting period, the target amount for the preceding cost reporting period, increase by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

''(ii) In clause (i), a 'qualified long-term care hospital' means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) during fiscal year 1995 for which the hospital's allowable operating costs of inpatient hospital services recognized under this title for each of the two most recent previous 12-month cost reporting periods exceeded the hospital's target amount determined under this paragraph for such cost reporting periods, if the hospital—

''(I) has a disproportionate patient percentage during such cost reporting period (as determined by the Secretary under subsection (d)(5)(F)(vi) as if the hospital were a subsection (d) hospital) of at least 25 percent, or

''(II) is located in a State for which no payment is made under the State plan under title XIX for days of inpatient hospital services furnished to any individual in excess of the limit on the number of days of such services furnished to the individual for which payment may be made under this title.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges occurring during cost reporting periods beginning on or after October 1, 1995.

(c) TREATMENT OF CERTAIN LONG-TERM CARE HOSPITALS LOCATED WITHIN OTHER HOSPITALS.—

(1) IN GENERAL.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended in the matter following clause (v) by striking the period and inserting the following: '', or a hospital classified by the Secretary as a long-term care hospital on or before September 30, 1995, and located in the same building as, or on the same campus as, another hospital.''.

(2) STUDY BY REVIEW COMMISSION.—Not later than 12 months after the date a majority of the members of the Medicare Payment Review Commission are first appointed, the Commission shall submit a report to Congress containing recommendations for appropriate revisions in the treatment of long-term care hospitals located in the same building as or on the same campus as another hospital for purposes of section 1886 of the Social Security Act.

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges occurring on or after October 1, 1995.

(d) STUDY OF PROSPECTIVE PAYMENT SYSTEM FOR REHABILITATION HOSPITALS AND UNITS.—

(1) IN GENERAL.—After consultation with the Prospective Payment Assessment Commission, providers of rehabilitation services, and other appropriate parties, the Secretary of Health and Human Services shall submit to Congress, by not later than June 1, 1996, a report on the advisability and feasibility of providing for payment based on a prospective payment system for inpatient services of rehabilitation hospitals and units under the medicare program.

(2) ITEMS INCLUDED.—The report shall include the following:

(A) The available and preferred systems of classifying rehabilitation patients relative to duration and intensity of inpatient services, including the use of functional-related groups (FRGs).

(B) The means of calculating medicare program payments to reflect such patient requirements.

(C) Other appropriate adjustments which should be made, such as for geographic variations in wages and other costs and outliers.

(D) A timetable under which such a system might be introduced.

(E) Whether such a system should be applied to other types of providers of inpatient rehabilitation services.

SEC. 15506. REDUCTION IN PAYMENTS TO HOSPITALS FOR ENROLLEES' BAD DEBTS.

(a) IN GENERAL.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(T)(i) In determining such reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced by—

''(I) 75 percent for cost reporting periods beginning during fiscal year 1996,

''(II) 60 percent for cost reporting periods beginning during fiscal year 1997, and

''(III) 50 percent for subsequent cost reporting periods.

''(ii) Clause (i) shall not apply with respect to bad debt of a hospital described in section 1886(d)(1)(B)(iv) if the debt is attributable to uncollectable deductible and coinsurance payments owed by individuals enrolled in a State plan under title XIX or under the MediGrant program under title XXI.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to hospital cost reporting periods beginning on or after October 1, 1995.

SEC. 15507. PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH.

Effective as if included in the enactment of OBRA–1989, section 6011(d) of such Act (as amended by section 13505 of OBRA–1993) is amended by striking ''and shall expire September 30, 1994''.

SEC. 15508. CONFORMING AMENDMENT TO CERTIFICATION OF CHRISTIAN SCIENCE PROVIDERS.

(a) HOSPITALS.—Section 1861(e) (42 U.S.C. 1395x(e)) is amended in the sixth sentence by inserting after ''Massachusetts,'' the following: ''or by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.,''.

(b) SKILLED NURSING FACILITIES.—Section 1861(y)(1) is amended by inserting after ''Massachusetts,'' the following: ''or by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.,''.

Subpart B—Provisions Relating to Rural Hospitals

SEC. 15511. SOLE COMMUNITY HOSPITALS.

(a) UPDATE.—Section 1886(b)(3)(B)(iv) (42 U.S.C. 1395ww(b)(3)(B)(iv)) is amended—

(A) in subclause (III), by striking ''and'' at the end; and

(B) by striking subclause (IV) and inserting the following:

''(IV) for each of the fiscal years 1996 through 2000, the market basket percentage increase minus 1 percentage points, and

''(V) for fiscal year 2001 and each subsequent fiscal year, the applicable percentage increase under clause (i).''.

(b) STUDY OF IMPACT OF SOLE COMMUNITY HOSPITAL DESIGNATIONS.—

(1) STUDY.—The Medicare Payment Review Commission shall conduct a study of the impact of the designation of hospitals as sole community hospitals under the medicare program on the delivery of health care services to individuals in rural areas, and shall include in the study an analysis of the characteristics of the hospitals designated as such sole community hospitals under the program.

(2) REPORT.—Not later than 12 months after the date a majority of the members of the Commission are first appointed, the Commission shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 15512. CLARIFICATION OF TREATMENT OF EAC AND RPC HOSPITALS.

Paragraphs (1)(A)(i) and (2)(A)(i) of section 1820(i) (42 U.S.C. 1395i@4(i)) are each amended by striking the semicolon at the end and inserting the following: '', or in a State which the Secretary finds would receive a grant under such subsection during a fiscal year if funds were appropriated for grants under such subsection for the fiscal year;''.

SEC. 15513. ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

''(oo)(1) The term 'rural emergency access care hospital' means, for a fiscal year, a facility with respect to which the Secretary finds the following:

''(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

''(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

''(C) The facility is in danger of closing due to low inpatient utilization rates and operating losses, and the closure of the facility would limit the access to emergency services of individuals residing in the facility's service area.

''(D) The facility has entered into (or plans to enter into) an agreement with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

''(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

''(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

''(G) The facility meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

''(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

''(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietitian, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

''(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph,

would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' were deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

''(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital and furnished to an individual over a continuous period not to exceed 24 hours (except that such services may be furnished over a longer period in the case of an individual who is unable to leave the hospital because of inclement weather):

''(A) An appropriate medical screening examination (as described in section 1867(a)).

''(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).''.

(b) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING REQUIREMENTS.—Section 1867(e)(5) (42 U.S.C. 1395dd(e)(5)) is amended by striking ''1861(mm)(1))'' and inserting ''1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(oo)(1))''.

(c) REFERENCE TO PAYMENT PROVISIONS UNDER PART B.—For provisions relating to payment for rural emergency access care hospital services under part B, see section 15607.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to fiscal years beginning on or after October 1, 1995.

SEC. 15514. CLASSIFICATION OF RURAL REFERRAL CENTERS.

(a) PROHIBITING DENIAL OF REQUEST FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.—

(1) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(A) by redesignating clause (iii) as clause (iv); and

(B) by inserting after clause (ii) the following new clause:

''(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which is classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.''.

(2) EFFECTIVE DATE.—Notwithstanding section 1886(d)(10)(C)(ii) of the Social Security Act, a hospital may submit an application to the Medicare Geographic Classification Review Board during the 30-day period beginning on the date of the enactment of this Act requesting a change in its classification for purposes of determining the area wage index applicable to the hospital under section 1886(d)(3)(D) of such Act for fiscal year 1997, if the hospital would be eligible for such a change in its classification under the standards described in section 1886(d)(10)(D) (as amended by paragraph (1)) but for its failure to meet the deadline for applications under section 1886(d)(10)(C)(ii).

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1994 shall be classified as such a rural referral center for fiscal year 1996 and each subsequent fiscal year.

SEC. 15515. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act for discharges occurring on or after October 1, 1995, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act) may not be less than the average of the area wage indices applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) BUDGET-NEUTRALITY IN IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage indices referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

PART 2—PAYMENTS TO SKILLED NURSING FACILITIES

SEC. 15521. PAYMENTS FOR ROUTINE SERVICE COSTS.

(a) CLARIFICATION OF DEFINITION OF ROUTINE SERVICE COSTS.—Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(e) For purposes of this section, the 'routine service costs' of a skilled nursing facility are all costs which are attributable to nursing services, room and board, administrative costs, other overhead costs, and all other ancillary services (including supplies and equipment), excluding costs attributable to covered non-routine services subject to payment limits under section 1888A.''.

(b) CONFORMING AMENDMENT.—Section 1888 (42 U.S.C. 1395yy) is amended in the heading by inserting ''AND CERTAIN ANCILLARY'' after ''SERVICE''.

SEC. 15522. INCENTIVES FOR COST EFFECTIVE MANAGEMENT OF COVERED NON-ROUTINE SERVICES.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following new section:

''INCENTIVES FOR COST-EFFECTIVE MANAGEMENT OF COVERED NON-ROUTINE SERVICES OF SKILLED NURSING FACILITIES

''SEC. 1888A. (a) DEFINITIONS.—For purposes of this section:

''(1) COVERED NON-ROUTINE SERVICES.—The term 'covered non-routine services' means post-hospital extended care services consisting of any of the following:

''(A) Physical or occupational therapy or speech-language pathology services, or respiratory therapy, including supplies and support services incident to such services and therapy.

''(B) Prescription drugs.

''(C) Complex medical equipment.

''(D) Intravenous therapy and solutions (including enteral and parenteral nutrients, supplies, and equipment).

''(E) Radiation therapy.

''(F) Diagnostic services, including laboratory, radiology (including computerized tomography services and imaging services), and pulmonary services.

''(2) SNF MARKET BASKET PERCENTAGE INCREASE.—The term 'SNF market basket percentage increase' for a fiscal year means a percentage equal to the percentage increase in routine service cost limits for the year under section 1888(a).

''(3) STAY.—The term 'stay' means, with respect to an individual who is a resident of a skilled nursing facility, a period of continuous days during which the facility provides extended care services for which payment may be made under this title with respect to the individual during the individual's spell of illness.

''(b) NEW PAYMENT METHOD FOR COVERED NON-ROUTINE SERVICES.—

''(1) IN GENERAL.—Subject to subsection (c), a skilled nursing facility shall receive interim payments under this title for covered non-routine services furnished to an individual during a cost reporting period beginning during a fiscal year (after fiscal year 1996) in an amount equal to the reasonable cost of providing such services in accordance with section 1861(v). The Secretary may adjust such payments if the Secretary determines (on the basis of such estimated information as the Secretary considers appropriate) that payments to the facility under this paragraph for a cost reporting period would substantially exceed the cost reporting period limit determined under subsection (c)(1)(B).

''(2) RESPONSIBILITY OF SKILLED NURSING FACILITY TO MANAGE BILLINGS.—

''(A) CLARIFICATION RELATING TO PART A BILLING.—In the case of a covered non-routine service furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility who is entitled to coverage under section 1812(a)(2) for such service, the skilled nursing facility shall submit a claim for payment under this title for such service under part A (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

''(B) PART B BILLING.—In the case of a covered non-routine service (other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility who is not entitled to coverage under section 1812(a)(2) for such service but is entitled to coverage under part B for such service, the skilled nursing facility shall submit a claim for payment under this title for such service under part B (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

''(C) MAINTAINING RECORDS ON SERVICES FURNISHED TO RESIDENTS.—Each skilled nursing facility receiving payments for extended care services under this title shall document on the facility's cost report all covered non-routine services furnished to all residents of the facility to whom the facility provided extended care services for which payment was made under part A during a fiscal year (beginning with fiscal year 1996) (without regard to whether or not the services were furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

''(c) RECONCILIATION OF AMOUNTS.—

''(1) LIMIT BASED ON PER STAY LIMIT AND NUMBER OF STAYS.—

''(A) IN GENERAL.—If a skilled nursing facility has received aggregate payments under subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in excess of an amount equal to the cost reporting period limit determined under subparagraph (B), the Secretary shall reduce the payments made to the facility with respect to such services for cost reporting periods beginning during the following fiscal year in an amount equal to such excess. The Secretary

shall reduce payments under this subparagraph at such times and in such manner during a fiscal year as the Secretary finds necessary to meet the requirement of this subparagraph.

''(B) COST REPORTING PERIOD LIMIT.—The cost reporting period limit determined under this subparagraph is an amount equal to the product of—

''(i) the per stay limit applicable to the facility under subsection (d) for the period; and

''(ii) the number of stays beginning during the period for which payment was made to the facility for such services.

''(C) PROSPECTIVE REDUCTION IN PAYMENTS.—In addition to the process for reducing payments described in subparagraph (A), the Secretary may reduce payments made to a facility under this section during a cost reporting period if the Secretary determines (on the basis of such estimated information as the Secretary considers appropriate) that payments to the facility under this section for the period will substantially exceed the cost reporting period limit for the period determined under this paragraph.

''(2) INCENTIVE PAYMENTS.—

''(A) IN GENERAL.—If a skilled nursing facility has received aggregate payments under subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in an amount that is less than the amount determined under paragraph (1)(B), the Secretary shall pay the skilled nursing facility in the following fiscal year an incentive payment equal to 50 percent of the difference between such amounts, except that the incentive payment may not exceed 5 percent of the aggregate payments made to the facility under subsection (b) for the previous fiscal year (without regard to subparagraph (B)).

''(B) INSTALLMENT INCENTIVE PAYMENTS.—The Secretary may make installment payments during a fiscal year to a skilled nursing facility based on the estimated incentive payment that the facility would be eligible to receive with respect to such fiscal year.

''(d) DETERMINATION OF FACILITY PER STAY LIMIT.—

''(1) LIMIT FOR FISCAL YEAR 1997.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary shall establish separate per stay limits for hospital-based and freestanding skilled nursing facilities for the 12-month cost reporting period beginning during fiscal year 1997 that are equal to the sum of—

''(i) 50 percent of the facility-specific stay amount for the facility (as determined under subsection (e)) for the last 12-month cost reporting period ending on or before September 30, 1994, increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997; and

''(ii) 50 percent of the average of all facility-specific stay amounts for all hospital-based facilities or all freestanding facilities (whichever is applicable) during the cost reporting period described in clause (i), increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997.

''(B) FACILITIES NOT HAVING 1994 COST REPORTING PERIOD.—In the case of a skilled nursing facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994, the per stay limit for the 12-month cost reporting period beginning during fiscal year 1997 shall be twice the amount determined under subparagraph (A)(ii).

''(2) LIMIT FOR SUBSEQUENT FISCAL YEARS.—The per stay limit for a skilled nursing facility for a 12-month cost reporting period beginning during a fiscal year after fiscal year 1997 is equal to the per stay limit established under this subsection for the 12-month cost reporting period beginning during the previous fiscal year, increased by the SNF market basket percentage increase for such subsequent fiscal year minus 2 percentage points.

''(3) REBASING OF AMOUNTS.—

''(A) IN GENERAL.—The Secretary shall provide for an update to the facility-specific amounts used to determine the per stay limits under this subsection for cost reporting periods beginning on or after October 1, 1999, and every 2 years thereafter.

''(B) TREATMENT OF FACILITIES NOT HAVING REBASED COST REPORTING PERIODS.—Paragraph (1)(B) shall apply with respect to a skilled nursing facility for which payments were not made under this title for covered non-routine services for the 12-month cost reporting period used by the Secretary to update facility-specific amounts under subparagraph (A) in the same manner as such paragraph applies with respect to a facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994.

''(e) DETERMINATION OF FACILITY-SPECIFIC STAY AMOUNTS.—The 'facility-specific stay amount' for a skilled nursing facility for a cost reporting period is the sum of—

''(1) the average amount of payments made to the facility under part A during the period which are attributable to covered non-routine services furnished during a stay; and

''(2) the Secretary's best estimate of the average amount of payments made under part B during the period for covered non-routine services furnished to all residents of the facility to whom the facility provided extended care services for which payment was made under part A during the period (without regard to whether or not the services were furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise), as estimated by the Secretary.

''(f) INTENSIVE NURSING OR THERAPY NEEDS.—

''(1) IN GENERAL.—In applying subsection (b) to covered non-routine services furnished during a stay beginning during a cost reporting period beginning during a fiscal year to a resident of a skilled nursing facility who requires intensive nursing or therapy services, the per stay limit determined for the fiscal year under the methodology for such resident shall be the per stay limit developed under paragraph (2) instead of the per stay limit determined under subsection (d)(1)(A).

''(2) PER STAY LIMIT FOR INTENSIVE NEED RESIDENTS.—Not later than June 30, 1996, the Secretary, after consultation with the Medicare Payment Review Commission and skilled nursing facility experts, shall develop and publish a methodology for determining on an annual basis a per stay limit for residents of a skilled nursing facility who require intensive nursing or therapy services.

''(3) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

''(g) SPECIAL TREATMENT FOR MEDICARE LOW VOLUME SKILLED NURSING FACILITIES.—This section shall not apply with respect to a skilled nursing facility for which payment is made for routine service costs during a cost reporting period on the basis of prospective payments under section 1888(d).

''(h) EXCEPTIONS AND ADJUSTMENTS TO LIMITS.—

''(1) IN GENERAL.—The Secretary may make exceptions and adjustments to the cost reporting limits applicable to a skilled nursing facility under subsection (c)(1)(B) for a cost reporting period, except that the total amount of any additional payments made under this section for covered non-routine services during the cost reporting period as a result of such exceptions and adjustments may not exceed 5 percent of the aggregate payments made to all skilled nursing facilities for covered non-routine services during the cost reporting period (determined without regard to this paragraph).

''(2) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

''(i) SPECIAL RULE FOR X-RAY SERVICES.—Before furnishing a covered non-routine service consisting of an X-ray service for which payment may be made under part A or part B to a resident, a skilled nursing facility shall consider whether furnishing the service through a provider of portable X-ray service services would be appropriate, taking into account the cost effectiveness of the service and the convenience to the resident.''.

(b) CONFORMING AMENDMENT.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking ''1813 and 1886'' and inserting ''1813, 1886, 1888, and 1888A''.

SEC. 15523. PAYMENTS FOR ROUTINE SERVICE COSTS.

(a) MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES.—

(1) BASING UPDATES TO PER DIEM COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—

(A) IN GENERAL.—The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by inserting before the period at the end the following: ''(except that such updates may not take into account any changes in the routine service costs of skilled nursing facilities occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995)''.

(B) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subparagraph (A) in making any adjustments pursuant to section 1888(c) of the Social Security Act.

(2) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Any change made by the Secretary of Health and Human Services in the amount of any prospective payment paid to a skilled nursing facility under section 1888(d) of the Social Security Act for cost reporting periods beginning on or after October 1, 1995, may not take into account any changes in the costs of services occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995.

(b) ESTABLISHMENT OF SCHEDULE FOR MAKING ADJUSTMENTS TO LIMITS.—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended by striking the period at the end of the second sentence and inserting '', and may only make adjustments under this subsection with respect to a facility which applies for an adjustment during an annual application period established by the Secretary.''.

(c) LIMITATION ON AGGREGATE INCREASE IN PAYMENTS RESULTING FROM ADJUSTMENTS TO LIMITS.—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended—

(1) by striking ''(c) The Secretary'' and inserting ''(c)(1) Subject to paragraph (2), the Secretary''; and

(2) by adding at the end the following new paragraph:

''(2) The Secretary may not make any adjustments under this subsection in the limits set forth in subsection (a) for a cost reporting period beginning during a fiscal year to the extent that the total amount of the additional payments made under this title as a result of such adjustments is greater than an amount equal to—

''(A) for cost reporting periods beginning during fiscal year 1997, the total amount of the additional payments made under this title as a result of adjustments under this subsection for cost reporting periods beginning during fiscal year 1996 increased by the SNF market basket percentage increase (as defined in section 1888A(e)(3)) for fiscal year 1997; and

''(B) for cost reporting periods beginning during a subsequent fiscal year, the amount determined under this paragraph for the previous fiscal year increased by the SNF market basket percentage increase for such subsequent fiscal year.''.

(d) IMPOSITION OF LIMITS FOR ALL COST REPORTING PERIODS.—Section 1888(a) (42 U.S.C. 1395yy(a)) is amended in the matter preceding paragraph (1) by inserting after ''extended care services'' the following: ''(for any cost reporting period for which payment is made under this title to the skilled nursing facility for such services)''.

SEC. 15524. REDUCTIONS IN PAYMENT FOR CAPITAL-RELATED COSTS.

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by section 15506, is amended by adding at the end the following new subparagraph:

''(U) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of skilled nursing facilities, the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1996 through 2002.''.

SEC. 15525. TREATMENT OF ITEMS AND SERVICES PAID FOR UNDER PART B.

(a) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO FACILITY.—

(1) IN GENERAL.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking ''and (D)'' and inserting ''(D)''; and

(B) by striking the period at the end and inserting the following: '', and (E) in the case of an item or service (other than physicians' services and other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, or otherwise).''.

(2) EXCLUSION FOR ITEMS AND SERVICES NOT BILLED BY FACILITY.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) by striking ''or'' at the end of paragraph (14);

(B) by striking the period at the end of paragraph (15) and inserting ''; or''; and

(C) by inserting after paragraph (15) the following new paragraph:

''(16) where such expenses are for covered non-routine services (as defined in section 1888A(a)(1)) (other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual who is a resident of a skilled nursing facility and for which the claim for payment under this title is not submitted by the facility.''.

(3) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by striking ''(2);'' and inserting ''(2) and section 1842(b)(6)(E);''.

(b) REDUCTION IN PAYMENTS FOR ITEMS AND SERVICES FURNISHED BY OR UNDER ARRANGEMENTS WITH FACILITIES.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by sections 15506 and 15524, is amended by adding at the end the following new subparagraph:

''(V) In the case of an item or service furnished by a skilled nursing facility (or by others under arrangement with them made by a skilled nursing facility) for which payment is made under part B in an amount determined in accordance with section 1833(a)(2)(B), the Secretary shall reduce the reasonable cost for such item or service otherwise determined under clause (i)(I) of such section by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1996 through 2002.''.

SEC. 15526. CERTIFICATION OF FACILITIES MEETING REVISED NURSING HOME REFORM STANDARDS.

(a) IN GENERAL.—Section 1819(a)(3) (42 U.S.C. 1395i@3(a)(3)) is amended to read as follows:

''(3)(A) is certified by the Secretary as meeting the standards established under subsection (b), or (B) is a State-certified facility (as defined in subsection (d)).''.

(b) REQUIREMENTS DESCRIBED.—Section 1819 (42 U.S.C. 1395i@3) is amended by striking subsections (b) through (i) and inserting the following:

''(b) STANDARDS FOR AND CERTIFICATION OF FACILITIES.—

''(1) STANDARDS FOR FACILITIES.—

''(A) IN GENERAL.—The Secretary shall provide for the establishment and maintenance of standards consistent with the contents described in subparagraph (B) for skilled nursing facilities which furnish services for which payment may be made under this title.

''(B) CONTENTS OF STANDARDS.—The standards established for facilities under this paragraph shall contain provisions relating to the following items:

''(i) The treatment of resident medical records.

''(ii) Policies, procedures, and bylaws for operation.

''(iii) Quality assurance systems.

''(iv) Resident assessment procedures, including care planning and outcome evaluation.

''(v) The assurance of a safe and adequate physical plant for the facility.

''(vi) Qualifications for staff sufficient to provide adequate care.

''(vii) Utilization review.

''(viii) The protection and enforcement of resident rights described in subparagraph (C).

''(C) RESIDENT RIGHTS DESCRIBED.—The resident rights described in this subparagraph are the rights of residents to the following:

''(i) To exercise the individual's rights as a resident of the facility and as a citizen or resident of the United States.

''(ii) To receive notice of rights and services.

''(iii) To be protected against the misuse of resident funds.

''(iv) To be provided privacy and confidentiality.

''(v) To voice grievances.

''(vi) To examine the results of inspections under the certification program.

''(vii) To refuse to perform services for the facility.

''(viii) To be provided privacy in communications and to receive mail.

''(ix) To have the facility provide immediate access to any resident by any representative of the certification program, the resident's individual physician, the State long term care ombudsman, and any person the resident has designated as a visitor.

''(x) To retain and use personal property.

''(xi) To be free from abuse, including verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.

''(xii) To be provided with prior written notice of a pending transfer or discharge.

''(D) REQUIRING NOTICE AND COMMENT.—The standards established for facilities under this paragraph may only take effect after the Secretary has provided the public with notice and an opportunity for comment.

''(2) CERTIFICATION PROGRAM.—

''(A) IN GENERAL.—The Secretary shall provide for the establishment and operation of a program consistent with the requirements of subparagraph (B) for the certification of skilled nursing facilities which meet the standards established under paragraph (1) and the decertification of facilities which fail to meet such standards.

''(B) REQUIREMENTS FOR PROGRAM.—In addition to any other requirements the Secretary may impose, in establishing and operating the certification program under subparagraph (A), the Secretary shall ensure the following:

''(i) The Secretary shall ensure public access (as defined by the Secretary) to the certification program's evaluations of participating facilities, including compliance records and enforcement actions and other reports by the Secretary regarding the ownership, compliance histories, and services provided by certified facilities.

''(ii) Not less often than every 4 years, the Secretary shall audit its expenditures under the program, through an entity designated by the Secretary which is not affiliated with the program, as designated by the Secretary.

''(c) INTERMEDIATE SANCTION AUTHORITY.—

''(1) AUTHORITY.—In addition to any other authority, where the Secretary determines that a nursing facility which is certified for participation under this title (whether certified by the Secretary as meeting the standards established under subsection (b) or a State-ceritified facility) no longer or does not substantially meet the requirements for such a facility under this title as specified under subsection (b) and further determines that the facility's deficiencies—

''(A) immediately jeopardize the health and safety of its residents, the Secretary shall at least provide for the termination of the facility's certification for participation under this title, or

''(B) do not immediately jeopardize the health and safety of its residents, the Secretary may, in lieu of providing for terminating the facility's certification for participation under the plan, provide lesser sanctions including one that provides that no payment will be made under this title with respect to any individual admitted to such facility after a date specified by the Secretary.

''(2) NOTICE.—The Secretary shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer or does not substantially meet the requirements for such a facility under this title, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

''(3) EFFECTIVENESS.—The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the

Secretary, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this title, or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the Secretary shall terminate such facility's certification for participation under this title effective with the first day of the first month following the month specified in such clause.

''(d) STATE-CERTIFIED FACILITY DEFINED.—In subsection (a), a 'State-certified facility' means a facility licensed or certified as a skilled nursing facility by the State in which it is located, or a facility which otherwise meets the requirements applicable to providers of nursing facility services under the State plan under title XIX or the MediGrant program under title XXI.''.

(c) CONFORMING AMENDMENTS.—(1) Section 1861(v)(1)(E) (42 U.S.C. 1395x(v)(1)(E)) is amended by striking the second sentence.

(2) Section 1864 (42 U.S.C. 1395aa) is amended by striking subsection (d).

(3) Section 1866(f)(1) (42 U.S.C. 1395cc(f)(1)) is amended by striking ''1819(c)(2)(E),''.

(4) Section 1883(f) (42 U.S.C. 1395tt(f)) is amended—

(A) in the second sentence, by striking ''such a hospital'' and inserting ''a hospital which enters into an agreement with the Secretary under this section''; and

(B) by striking the first sentence.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to cost reporting periods beginning on or after October 1, 1995.

SEC. 15527. MEDICAL REVIEW PROCESS.

In order to ensure that medicare beneficiaries are furnished appropriate extended care services, the Secretary of Health and Human Services shall establish and implement a thorough medical review process to examine the effects of the amendments made by this part on the quality of extended care services furnished to medicare beneficiaries. In developing such a medical review process, the Secretary shall place a particular emphasis on the quality of non-routine covered services for which payment is made under section 1888A of the Social Security Act.

SEC. 15528. REPORT BY MEDICARE PAYMENT REVIEW COMMISSION.

Not later than October 1, 1997, the Medicare Payment Review Commission shall submit to Congress a report on the system under which payment is made under the medicare program for extended care services furnished by skilled nursing facilities, and shall include in the report the following:

(1) An analysis of the effect of the methodology established under section 1888A of the Social Security Act (as added by section 15522) on the payments for, and the quality of, extended care services under the medicare program.

(2) An analysis of the advisability of determining the amount of payment for covered non-routine services of facilities (as described in such section) on the basis of the amounts paid for such services when furnished by suppliers under part B of the medicare program.

(3) An analysis of the desirability of maintaining separate limits for hospital-based and freestanding facilities in the costs of extended care services recognized as reasonable under the medicare program.

(4) An analysis of the quality of services furnished by skilled nursing facilities.

(5) An analysis of the adequacy of the process and standards used to provide exceptions to the limits described in paragraph (3).

SEC. 15529. EFFECTIVE DATE.

Except as otherwise provided in this part, the amendments made by this part shall apply to services furnished during cost reporting periods (or portions of cost reporting periods) beginning on or after October 1, 1996.

PART 3—CLARIFICATION OF CREDITS TO PART A TRUST FUND

SEC. 15531. CLARIFICATION OF AMOUNT OF TAXES CREDITED TO FEDERAL HOSPITAL INSURANCE TRUST FUND.

Section 121(e)(1)(B) of the Social Security Amendments of 1983 (Public Law 98–21) is amended by adding at the end the following: ''The Secretary of the Treasury shall carry out this subparagraph without regard to any amendments to this subsection or to section 86 of the Internal Revenue Code of 1986 which take effect on or after January 1, 1994.''.

Subtitle G—Provisions Relating to Medicare Part B

PART 1—PAYMENT REFORMS

SEC. 15601. PAYMENTS FOR PHYSICIANS' SERVICES.

(a) REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.—Section 1848(f) (42 U.S.C. 1395w@4(f)) is amended to read as follows:

''(f) SUSTAINABLE GROWTH RATE.—

''(1) SPECIFICATION OF GROWTH RATE.—

''(A) FISCAL YEAR 1996.—The sustainable growth rate for all physicians' services for fiscal year 1996 shall be equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for 1996 (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

''(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from fiscal year 1995 to fiscal year 1996,

''(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from fiscal year 1995 to fiscal year 1996, plus 2 percentage points, and

''(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in fiscal year 1996 (compared with fiscal year 1995) which will result from changes in law, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d),

minus 1 and multiplied by 100.

''(B) SUBSEQUENT FISCAL YEARS.—The sustainable growth rate for all physicians' services for fiscal year 1997 and each subsequent fiscal year shall be equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for the fiscal year involved (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

''(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from the previous fiscal year to the fiscal year involved,

''(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, plus 2 percentage points, and

''(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law (including changes made by the Secretary in response to section 1895), determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d)(3),

minus 1 and multiplied by 100.

''(2) EXCLUSION OF SERVICES FURNISHED TO PRIVATE PLAN ENROLLEES.—In this subsection, the term 'physicians' services' with respect to a fiscal year does not include services furnished to an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a MedicarePlus product offered under part C or through enrollment with an eligible organization with a risk-sharing contract under section 1876.''.

(b) ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w@4(d)) is amended—

(A) by striking paragraph (2);

(B) by amending paragraph (3) to read as follows:

''(3) UPDATE.—

''(A) IN GENERAL.—Subject to subparagraph (E), for purposes of this section the update for a year (beginning with 1997) is equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100), and

''(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

''(B) UPDATE ADJUSTMENT FACTOR.—The 'update adjustment factor' for a year is equal to the quotient of—

''(i) the difference between (I) the sum of the allowed expenditures for physicians' services furnished during each of the years 1995 through the year involved and (II) the sum of the amount of actual expenditures for physicians' services furnished during each of the years 1995 through the previous year; divided by

''(ii) the Secretary's estimate of allowed expenditures for physicians' services furnished during the year.

''(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of subparagraph (B), allowed expenditures for physicians' services shall be determined as follows (as estimated by the Secretary):

''(i) In the case of allowed expenditures for 1995, such expenditures shall be equal to actual expenditures for services furnished during the 12-month period ending with June of 1995.

''(ii) In the case of allowed expenditures for 1996 and each subsequent year, such expenditures shall be equal to allowed expenditures for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during the year.

''(D) DETERMINATION OF ACTUAL EXPENDITURES.—For purposes of subparagraph (B), the amount of actual expenditures for physicians' services furnished during a year shall be equal to the amount of expenditures for such services during the 12-month period ending with June of the previous year.

''(E) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—

''(i) IN GENERAL.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year,

the update in the conversion factor under this paragraph for the year may not be—

''(I) greater than 103 percent of 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100); or

''(II) less than the applicable percentage limit of 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100).

''(ii) APPLICABLE PERCENTAGE LIMIT.—In clause (i)(II), the 'applicable percentage limit' for a year is—

''(I) for 1997, 93 percent;

''(II) for 1998, 92.25 percent; and

''(III) for 1999 and each succeeding year, 92 percent.''; and

(C) by adding at the end the following new paragraph:

''(4) REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—Not later than November 1 of each year (beginning with 1996), the Secretary shall transmit to the Congress a report that describes the update in the conversion factor for physicians' services (as defined in subsection (f)(3)(A)) in the following year.

''(B) COMMISSION REVIEW.—The Medicare Payment Review Commission shall review the report submitted under subparagraph (A) for a year and shall submit to the Congress, by not later than December 1 of the year, a report containing its analysis of the conversion factor for the following year.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to physicians' services furnished on or after January 1, 1996.

(c) ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1996.—

(1) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w@4(d)(1)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (D); and

(B) by inserting after subparagraph (B) the following new subparagraph:

''(C) SPECIAL RULE FOR 1996.—For 1996, the conversion factor under this subsection shall be $35.42 for all physicians' services.''.

(2) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w@4), as amended by paragraph (1), is amended—

(A) by striking ''(or factors)'' each place it appears in subsection (d)(1)(A) and (d)(1)(D)(ii);

(B) in subsection (d)(1)(A), by striking ''or updates'';

(C) in subsection (d)(1)(D)(ii), by striking ''(or updates)''; and

(D) in subsection (i)(1)(C), by striking ''conversion factors'' and inserting ''the conversion factor''.

SEC. 15602. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1995.

SEC. 15603. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT.

(a) REDUCTION IN PAYMENT AMOUNTS FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(1) FREEZE IN UPDATE FOR COVERED ITEMS.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(A) by striking ''and'' at the end of subparagraph (A);

(B) in subparagraph (B)—

(i) by striking ''a subsequent year'' and inserting ''1993, 1994, and 1995'', and

(ii) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following:

''(C) for each of the years 1996 through 2002, 0 percentage points; and

''(D) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.''.

(2) UPDATE FOR ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended—

(A) by striking ''and'' at the end of clause (iii);

(B) by redesignating clause (iv) as clause (v); and

(C) by inserting after clause (iii) the following new clause:

''(iv) for each of the years 1996 through 2002, 1 percent, and''.

(b) OXYGEN AND OXYGEN EQUIPMENT.—Section 1834(a)(9)(C) (42 U.S.C. 1395m(a)(9)(C)) is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) in clause (iv)—

(A) by striking ''a subsequent year'' and inserting ''1993, 1994, and 1995'', and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new clauses:

''(v) in 1996, is 80 percent of the national limited monthly payment rate computed under subparagraph (B) for the item for the year; and

''(vi) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for the year.''.

(c) PAYMENT FOR UPGRADED DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following new paragraph:

''(16) PAYMENT FOR CERTAIN UPGRADED ITEMS.—

''(A) INDIVIDUAL'S RIGHT TO CHOOSE UPGRADED ITEM.—Notwithstanding any other provision of this title, effective on the date on which the Secretary issues regulations under subparagraph (C), payment may be made under this part for an upgraded item of durable medical equipment in the same manner as payment may be made for a standard item of durable medical equipment.

''(B) PAYMENTS TO SUPPLIER.—In the case of the purchase or rental of an upgraded item under subparagraph (A)—

''(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

''(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i).

In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

''(C) CONSUMER PROTECTION SAFEGUARDS.—The Secretary shall issue regulations providing for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

''(i) full disclosure by the supplier of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item;

''(ii) conditions of participation for suppliers of upgraded items, including conditions relating to billing procedures;

''(iii) sanctions (including exclusion) of suppliers who are determined to have engaged in coercive or abusive practices; and

''(iv) such other safeguards as the Secretary determines are necessary.''.

(d) PAYMENT FREEZE FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—In determining the amount of payment under part B of title XVIII of the Social Security Act with respect to parenteral and enteral nutrients, supplies, and equipment during each of the years 1996 through 2002, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the charges determined to be reasonable with respect to such nutrients, supplies, and equipment during 1993.

SEC. 15604. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) CHANGE IN UPDATE.—Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV)) is amended by striking ''1994 and 1995'' and inserting ''1994 through 2002''.

(b) LOWERING CAP ON PAYMENT AMOUNTS.—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

(1) in clause (vi), by striking ''and'' at the end;

(2) in clause (vii)—

(A) by inserting ''and before January 1, 1997,'' after ''1995,'', and

(B) by striking the period at the end and inserting '', and''; and

(3) by adding at the end the following new clause:

''(viii) after December 31, 1996, is equal to 65 percent of such median.''.

SEC. 15605. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking ''through 1998'' and inserting ''through 2002''.

(b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking ''through 1998'' and inserting ''through 2002''.

SEC. 15606. FREEZE IN PAYMENTS FOR AMBULATORY SURGICAL CENTER SERVICES.

The Secretary of Health and Human Services shall not provide for any inflation update in the payment amounts under subparagraphs (A) and (B) of section 1833(i)(2) of the Social Security Act for any of the fiscal years 1996 through 2002.

SEC. 15607. RURAL EMERGENCY ACCESS CARE HOSPITALS.

(a) COVERAGE UNDER PART B.—Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

(1) by striking ''and'' at the end of subparagraph (I);

(2) by striking the period at the end of subparagraph (J) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).''.

(b) PAYMENT BASED ON PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1833(a)(6) (42 U.S.C. 1395l(a)(6)) is amended by striking ''services,'' and inserting ''services and rural emergency access care hospital services,''.

(2) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) (42 U.S.C. 1395m(g)) is amended—

(A) in the heading, by striking ''SERVICES'' and inserting ''SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES''; and

(B) by adding at the end the following new sentence: ''The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1995.

SEC. 15608. ENSURING PAYMENT FOR PHYSICIAN AND NURSE FOR JOINTLY FURNISHED ANESTHESIA SERVICES.

(a) PAYMENT FOR JOINTLY FURNISHED SINGLE CASE.—

(1) PAYMENT TO PHYSICIAN.—Section 1848(a)(4) (42 U.S.C. 1395w@4(a)(4)) is amended by adding at the end the following new subparagraph:

''(C) PAYMENT FOR SINGLE CASE.—Notwithstanding section 1862(a)(1)(A), with respect to physicians' services consisting of the furnishing of anesthesia services for a single case that are furnished jointly with a certified registered nurse anesthetist, if the carrier determines that the use of both the physician and the nurse anesthetist to furnish the anesthesia service was not medically necessary, the fee schedule amount for the physicians' services shall be equal to 50 percent (or 55 percent, in the case of services furnished during 1996 or 1997) of the fee schedule amount applicable under this section for anesthesia services personally performed by the physician alone (without regard to this subparagraph). Nothing in this subparagraph may be construed to affect the application of any provision of law regarding balance billing.''.

(2) PAYMENT TO CRNA.—Section 1833(l)(4)(B) (42 U.S.C. 1395l(l)(4)(B)) is amended by adding at the end the following new clause:

''(iv) Notwithstanding section 1862(a)(1)(A), in the case of services of a certified registered nurse anesthetist consisting of the furnishing of anesthesia services for a single case that are furnished jointly with a physician, if the carrier determines that the use of both the physician and the nurse anesthetist to furnish the anesthesia service was not medically necessary, the fee schedule amount for the services furnished by the certified registered nurse anesthetist shall be equal to 50 percent (or 40 percent, in the case of services furnished during 1996 or 1997) of the fee schedule amount applicable under section 1848 for anesthesia services personally performed by the physician alone (without regard to this clause).''.

(b) EFFECTIVE DATE.—The amendments made by subsections (a) shall apply to services furnished on or after July 1, 1996.

SEC. 15609. STATEWIDE FEE SCHEDULE AREA FOR PHYSICIANS' SERVICES.

(a) IN GENERAL.—Notwithstanding section 1848(j)(2) of the Social Security Act, in the case of the State of Wisconsin, the Secretary of Health and Human Services shall treat the State as a single fee schedule area for purposes of determining the fee schedule amount (as referred to in section 1848(a) of such Act) for physicians' services (as defined in section 1848(j)(3) of such Act) under part B of the medicare program.

(b) BUDGET-NEUTRALITY.—Notwithstanding any provision of part B of title XVIII of the Social Security Act, the Secretary shall carry out subsection (a) in a manner that ensures that total payments for physicians' services (as so defined) furnished by physicians in Wisconsin during a year are not greater or less than total payments for such services would have been but for this section.

(c) CONSTRUCTION.—Nothing in this section shall be construed as limiting the availability (to the Secretary, the appropriate agency or organization with a contract under section 1842 of such Act, or physicians in the State of Wisconsin) of otherwise applicable administrative procedures for modifying the fee schedule area or areas in the State after implementation of subsection (a).

(d) EFFECTIVE DATE.—This section shall apply with respect to physicians' services furnished on or after January 1, 1997.

SEC. 15609A. ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.

(a) PAYMENT IN ACCORDANCE WITH FEE SCHEDULE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(1) by striking ''and (P)'' and inserting ''(P)''; and

(2) by striking the semicolon at the end and inserting the following: '', and (Q) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (in accordance with section 15608(b) of the Medicare Preservation Act);''.

(b) REQUIREMENTS FOR ESTABLISHMENT OF FEE SCHEDULE.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish the fee schedule for ambulance services under section 1833(a)(1)(Q) of the Social Security Act (as added by subsection (a)) through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

(2) CONSIDERATIONS.—In establishing the fee schedule for ambulance services, the Secretary shall—

(A) establish mechanisms to control increases in expenditures for ambulance services under part B of the medicare program which fairly reflect the changing nature of the ambulance service industry;

(B) establish definitions for ambulance services which promote efficiency and link payments (including fees for assessment and treatment services) to the type of service provided;

(C) take into account regional differences which affect cost and productivity, including differences in the costs of resources and the costs of uncompensated care;

(D) apply dynamic adjustments to payment rates to account for inflation, demographic changes in the population of medicare beneficiaries, and changes in the number of providers of ambulance services participating in the medicare program; and

(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

(3) SAVINGS.—In establishing the fee schedule for ambulance services, the Secretary shall—

(A) ensure that the aggregate amount of payments made for ambulance services under part B of the medicare program during 1998 does not exceed the aggregate amount of payments which would have been made for such services under part B of the program during 1998 if the amendments made by this section were not in effect; and

(B) set the payment amounts provided under the fee schedule for services furnished in 1999 and each subsequent year at amounts equal to the payment amounts under the fee schedule for service furnished during the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

(4) CONSULTATION.—In establishing the fee schedule for ambulance services, the Secretary shall consult regularly with the American Ambulance Association, the National Association of State Medical Directors, and other national organizations representing individuals and entities who furnish or regulate ambulance services, and shall share with such associations and organizations the data and data analysis used in establishing the fee schedule, including data on variations in payments for ambulance services under part B of the medicare program for years prior to 1998 among geographic areas and types of ambulance service providers.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) and the fee schedule described in subsection (b) shall apply to ambulance services furnished on or after January 1, 1998.

SEC. 15609B. STANDARDS FOR PHYSICAL THERAPY SERVICES FURNISHED BY PHYSICIANS.

(a) APPLICATION OF STANDARDS FOR OTHER PROVIDERS OF PHYSICAL THERAPY SERVICES TO SERVICES FURNISHED BY PHYSICIANS.—[*Review for previous (and subsequent) amendments!*] Section 1862(a) (42 U.S.C. 1395y(a)), as amended by sectio 15525(a)(2), is amended

(1) by striking ''or'' at the end of paragraph (15);

(2) by striking the period at the end of paragraph (16) and inserting ''; or''; and

(3) by inserting after paragraph (16) the following new paragraph:

''(17) in the case of physicians' services under section 1848(j)(3) consisting of outpatient physical therapy services or outpatient occupational therapy services, which are furnished by a physician who does not meet the requirements applicable under section 1861(p) to a clinic or rehabilitation agency furnishing such services.''.

(b) CONFORMING AMENDMENT.—Section 1848(j)(3) (42 U.S.C. 1395w@4(j)(3)) is amended by inserting ''(subject to section 1862(a)(17))'' after ''(2)(D)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1996.

PART 2—PART B PREMIUM

SEC. 15611. EXTENSION OF PART B PREMIUM.

(a) IN GENERAL.—Section 1839(e)(1) (42 U.S.C. 1395r(e)(1)) is amended—

(1) in subparagraph (A)—

(A) by striking ''and prior to January 1999'', and

(B) by inserting ''(or, if higher, the percent described in subparagraph (C))'' after ''50 percent''; and

(2) by adding at the end the following new subparagraph:

''(C) For purposes of subparagraph (A), the percent described in this subparagraph is the ratio (expressed as a percentage) of the monthly premium established under this section for months in 1995 to the monthly actuarial rate for enrollees age 65 and over applicable to such months (as specified in the most recent report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund published prior to the date of the enactment of the Medicare Preservation Act of 1995).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to premiums for months beginning with January 1996.

SEC. 15612. INCOME-RELATED REDUCTION IN MEDICARE SUBSIDY.

(a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following:

''(h)(1) Notwithstanding the previous subsections of this section, in the case of an individual whose modified adjusted gross income for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (3)) exceeds the threshold amount described in paragraph (5)(B), the Secretary shall increase the amount of the monthly

premium for months in the calendar year by an amount equal to the difference between—

''(A) 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for that calendar year; and

''(B) the total of the monthly premiums paid by the individual under this section (determined without regard to subsection (b)) during such calendar year.

''(2) In the case of an individual described in paragraph (1) whose modified adjusted gross income exceeds the threshold amount by less than $25,000, the amount of the increase in the monthly premium applicable under paragraph (1) shall be an amount which bears the same ratio to the amount of the increase described in paragraph (1) (determined without regard to this paragraph) as such excess bears to $25,000. In the case of a joint return filed under section 6013 of the Internal Revenue Code of 1986 by spouses both of whom are enrolled under this part, the previous sentence shall be applied by substituting '$50,000' for '$25,000'. The preceding provisions of this paragraph shall not apply to any individual whose threshold amount is zero.

''(3) The Secretary shall make an initial determination of the amount of an individual's modified adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

''(A) Not later than October 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual modified adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary's estimate of the individual's modified adjusted gross income for the year.

''(B) If, during the 30-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with information on the individual's anticipated modified adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

''(C) If an individual does not provide the Secretary with information under subparagraph (B), the amount initially determined by the Secretary under this paragraph with respect to the individual shall be the amount included in the notice provided to the individual under subparagraph (A).

''(4)(A) If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual modified adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (3), the Secretary shall increase or decrease the amount of the individual's monthly premium under this section (as the case may be) for months during the following calendar year by an amount equal to 1/12 of the difference between—

''(i) the total amount of all monthly premiums paid by the individual under this section during the previous calendar year; and

''(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual's modified adjusted gross income initially determined under paragraph (3) were equal to the actual amount of the individual's modified adjusted gross income determined under this paragraph.

''(B) In the case of an individual who is not enrolled under this part for any calendar year for which the individual's monthly premium under this section for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual's monthly premium for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

''(C) In the case of a deceased individual for whom the amount of the monthly premium under this section for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual's surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual's estate) in an amount equal to the difference between—

''(i) the total amount by which the individual's premium would have been decreased for all months during the year pursuant to subparagraph (A); and

''(ii) the amount (if any) by which the individual's premium was decreased for months during the year pursuant to subparagraph (A).

''(5) In this subsection, the following definitions apply:

''(A) The term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

''(i) determined without regard to sections 135, 911, 931, and 933 of such Code, and

''(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

''(B) The term 'threshold amount' means—

''(i) except as otherwise provided in this paragraph, $75,000,

''(ii) $125,000, in the case of a joint return (as defined in section 7701(a)(38) of such Code), and

''(iii) zero in the case of a taxpayer who—

''(I) is married at the close of the taxable year but does not file a joint return (as so defined) for such year, and

''(II) does not live apart from his spouse at all times during the taxable year.''.

(b) CONFORMING AMENDMENT.—Section 1839(f) (42 U.S.C. 1395r(f)) is amended by striking ''if an individual'' and inserting the following: ''if an individual (other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))''.

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to confidentiality and disclosure of returns and return information) is amended by adding at the end the following new paragraph:

''(15) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT INCOME-RELATED REDUCTION IN MEDICARE PART B PREMIUM.—

''(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Health Care Financing Administration return information with respect to a taxpayer who is required to pay a monthly premium under section 1839 of the Social Security Act. Such return information shall be limited to—

''(i) taxpayer identity information with respect to such taxpayer,

''(ii) the filing status of such taxpayer,

''(iii) the adjusted gross income of such taxpayer,

''(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911,

''(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available, and

''(vi) the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Health Care Financing Administration only for the purposes of, and to the extent necessary in, establishing the appropriate monthly premium under section 1839 of the Social Security Act.''

(2) CONFORMING AMENDMENT.—Paragraphs (3)(A) and (4) of section 6103(p) of such Code are each amended by striking ''or (14)'' each place it appears and inserting ''(14), or (15)''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning with January 1997.

PART 3—ADMINISTRATION AND BILLING OF LABORATORY SERVICES

SEC. 15621. ADMINISTRATIVE SIMPLIFICATION FOR LABORATORY SERVICES.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in accordance with the process described in subsection (b)) shall adopt uniform coverage, administration, and payment policies for clinical diagnostic laboratory tests under part B of the medicare program.

(b) PROCESS FOR ADOPTION OF POLICIES.—The Secretary shall adopt uniform policies under subsection (a) in accordance with the following process:

(1) The Secretary shall select from carriers with whom the Secretary has a contract under part B during 1995 15 medical directors, who will meet and develop recommendations for such uniform policies. The medical directors selected shall represent various geographic areas and have a varied range of experience in relevant medical fields, including pathology and clinical laboratory practice.

(2) The medical directors selected under paragraph (1) shall consult with independent experts in each major discipline of clinical laboratory medicine, including clinical laboratory personnel, bioanalysts, pathologists, and practicing physicians. The medical directors shall also solicit comments from other individuals and groups who wish to participate, including consumers and other affected parties. This process shall be conducted as a negotiated rulemaking under title 5, United States Code.

(3) Under the negotiated rulemaking, the recommendations for uniform policies shall be designed to simplify and reduce unnecessary administrative burdens in connection with the following:

(A) Beneficiary information required to be submitted with each claim.

(B) Physicians' obligations regarding documentation requirements and recordkeeping.

(C) Procedures for filing claims and for providing remittances by electronic media.

(D) The performance of post-payment review of test claims.

(E) The prohibition of the documentation of medical necessity except when determined

to be appropriate after identification of aberrant utilization pattern through focused medical review.

(F) Beneficiary responsibility for payment.

(4) During the pendency of the adoption by the Secretary of the uniform policies, fiscal intermediaries and carriers under the medicare program may not implement any new requirement relating to the submission of a claim for clinical diagnostic laboratory tests retroactive to January 1, 1995, and carriers may not initiate any new coverage, administrative, or payment policy unless the policy promotes the goal of administrative simplification of requirements imposed on clinical laboratories in accordance with the Secretary's promulgation of the negotiated rulemaking.

(5) Not later than 6 months after the date of the enactment of this Act, the medical directors shall submit their recommendations to the Secretary, and the Secretary shall publish the recommendations and solicit public comment using negotiated rulemaking in accordance with title 5, United States Code. The Secretary shall publish final uniform policies for coverage, administration, and payment of claims for clinical diagnostic laboratory tests, effective after the expiration of the 180-day period which begins on the date of publication.

(6) After the publication of the final uniform policies, the Secretary shall implement identical uniform documentation and processing policies for all clinical diagnostic laboratory tests paid under the medicare program through fiscal intermediaries or carriers.

(c) OPTIONAL SELECTION OF SINGLE CARRIER.—Effective for claims submitted after the expiration of the 90-day period which begins on the date of the enactment of this Act, an independent laboratory may select a single carrier for the processing of all of its claims for payment under part B of the medicare program, without regard to the location where the laboratory or the patient or provider involved resides or conducts business. Such election of a single carrier shall be made by the clinical laboratory and an agreement made between the carrier and the laboratory shall be forwarded to the Secretary of Health and Human Services. Nothing in this subsection shall be construed to require a laboratory to select a single carrier under this subsection.

SEC. 15622. RESTRICTIONS ON DIRECT BILLING FOR LABORATORY SERVICES.

(a) REQUIREMENT FOR DIRECT BILLING.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following new paragraph:

''(7)(A) Effective for services furnished on or October 1, 1996, an individual or entity that performs clinical laboratory diagnostic tests shall not present or cause to be presented a claim, bill, or demand for payment to any person, other than the individual receiving such services or the health plan designated by such person, except that (i) in the case of a test performed by one laboratory at the request of another laboratory, which meets the requirements of clause (i), (ii), or (iii) of paragraph (5)(A), payment may be made to the requesting laboratory, and (ii) the Secretary may by regulation establish appropriate exceptions to the requirement of this subparagraph.

''(B)(i) Any person that collects any amounts that were billed in violation of paragraph (7)(A) above shall be liable for such amounts to the person from whom such amounts were collected.

''(ii) Any person that furnishes clinical laboratory services for which payment is made under paragraph (1)(D)(i) or paragraph (2)(D)(i) that knowingly violates subparagraph (A) is subject to a civil money penalty of not more than $10,000 for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

''(iii)(I) Any individual or entity that the Secretary determines has repeatedly violated subparagraph (A) may be excluded from participation in any Federal health care program . The provisions of section 1128A (other than subsections (a) and (b)) shall apply to an exclusion under this paragraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

''(II) The provisions of section 1128(e) of the Social Security Act shall apply to any exclusion under clause (iii)(I) in the same manner as such provisions apply to a proceeding under section 1128.

''(iv) If the Secretary finds, after a reasonable notice and opportunity for a hearing, that a laboratory which holds a certificate pursuant to section 353 of the Public Health Service Act has on a repeated basis violated subparagraph (A), the Secretary may suspend, revoke, or limit such certification in accordance with the procedures established in section 353(k) of Public Health Service Act.

''(C) For purposes of this paragraph, the following definitions shall apply:

''(i) The term 'Federal health care program' means—

''(I) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded, in whole or in part, by the United States Government; or

''(II) any State health care program, as defined in section 1128(h).

''(ii) The term 'health plan' means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by an insurer, except that such term does not include any of the following:

''(I) Coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof.

''(II) Medicare supplemental health insurance.

''(III) Coverage issued as a supplement to liability insurance.

''(IV) Liability insurance, including general liability insurance and automobile liability insurance.

''(V) Worker's compensation or similar insurance.

''(VI) Automobile medical-payment insurance.

''(VII) Coverage for a specified disease or illness.

''(VIII) A hospital or fixed indemnity policy.

(b) LOOK BACK PROVISIONS TO ASSURE SAVINGS.—

(1) IN GENERAL.—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)), as amended by section 15604(b), is amended—

(A) in clause (vii), by striking ''and'' at the end;

(B) in clause (viii)—

(i) by inserting ''and before January 1, 2000,'' after ''1996,'', and

(ii) by striking the period at the end and inserting '', and''; and

(C) by adding at the end the following new clause:

''(ix) after December 31, 1999, is equal to such percentage of such median as the Secretary establishes under paragraph (8)(B), or, if the Secretary does not act under paragraph (8)(B), is equal to 65 percent of such median.''.

(2) PROCESS FOR REDUCTIONS.—Section 1833(h) (42 U.S.C. 1395l(h)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(8)(A) On July 31, 1999, the Secretary shall estimate—

''(i) the amount of expenditures under this section for clinical diagnostic laboratory tests which will be made in the period from January 1, 1997, through September 30, 2002, and

''(ii) the amount of expenditures which would have been made under this section for clinical diagnostic laboratory tests in the period from January 1, 997, through September 30, 2002, if paragraph (7) had not been enacted.

''(B) If the amount estimated under subparagraph (A)(i) is greater than 97 percent of the amount estimated under subparagraph (A)(ii), the Secretary shall establish a limitation amount under paragraph (4)(B)(ix) such that, when such limitation amount is considered, the amount estimated under subparagraph (A)(i) is 97 percent of the amount estimated under subparagraph (A)(ii).

''(C) The Director of the Congressional Budget Office (hereafter in this subparagraph referred to as the 'Director') shall—

''(i) independently estimate the amounts specified in subparagraph (A) and compute any limitation amount required under subparagraph (B), and

''(ii) submit a report on such estimates and computation to Congress not later than August 31, 1999.

The Secretary shall provide the Director with such data as the Director reasonably requires to prepare such estimates and computation.''.

PART 4—QUALITY STANDARDS FOR DURABLE MEDICAL EQUIPMENT

SEC. 15631. RECOMMENDATIONS FOR QUALITY STANDARDS FOR DURABLE MEDICARE EQUIPMENT.

(a) APPOINTMENT OF TASK FORCE BY SECRETARY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish a broadly based task force to develop recommendations for quality standards for durable medical equipment under part B of the medicare program.

(2) COMPOSITION.—The task force shall include individuals selected by the Secretary from representatives of suppliers of items of durable medical equipment under part B, consumers, and other users of such equipment. In appointing members, the Secretary shall assure representation from various geographic regions of the United States.

(3) NO COMPENSATION FOR SERVICE.—Members of the task force shall not receive any compensation for service on the task force.

(4) TERMINATION.—The task force shall terminate 30 days after it submits the report described in subsection (b).

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the task force established under subsection (a) shall submit to the Secretary its recommendations for quality standards for durable medicare equipment under part B of the medicare program.

Subtitle H—Provisions Relating to Medicare Parts A and B

PART 1—PAYMENTS FOR HOME HEALTH SERVICES

SEC. 15701. PAYMENT FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 15106, is amended by adding at the end the following new section:

''PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1894. (a) IN GENERAL.—

''(1) PER VISIT PAYMENTS.—Subject to subsection (c), the Secretary shall make per visit payments beginning with fiscal year 1997 to a home health agency in accordance with this section for each type of home health service described in paragraph (2) furnished to an individual who at the time the service is furnished is under a plan of care by the home health agency under this title (without regard to whether or not the item or service was furnished by the agency or by others under arrangement with them made by the agency, or otherwise).

''(2) TYPES OF SERVICES.—The types of home health services described in this paragraph are the following:

''(A) Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.

''(B) Physical therapy.

''(C) Occupational therapy.

''(D) Speech-language pathology services.

''(E) Medical social services under the direction of a physician.

''(F) To the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary.

''(b) ESTABLISHMENT OF PER VISIT RATE FOR EACH TYPE OF SERVICES.—

''(1) IN GENERAL.—The Secretary shall, subject to paragraph (3), establish a per visit payment rate for a home health agency in an area for each type of home health service described in subsection (a)(2). Such rate shall be equal to the national per visit payment rate determined under paragraph (2) for each such type, except that the labor-related portion of such rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located (as determined without regard to any reclassification of the area under section 1886(d)(8)(B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under section 1886(d)(10) for cost reporting periods beginning after October 1, 1995).

''(2) NATIONAL PER VISIT PAYMENT RATE.—The national per visit payment rate for each type of service described in subsection (a)(2)—

''(A) for fiscal year 1997, is an amount equal to the national average amount paid per visit under this title to home health agencies for such type of service during the most recent 12-month cost reporting period ending on or before June 30, 1994, increased (in a compounded manner) by the home health market basket percentage increase for fiscal years 1995, 1996, and 1997; and

''(B) for each subsequent fiscal year, is an amount equal to the national per visit payment rate in effect for the preceding fiscal year, increased by the home health market basket percentage increase for such subsequent fiscal year minus 2 percentage points.

''(3) REBASING OF RATES.—The Secretary shall provide for an update to the national per visit payment rates under this subsection for cost reporting periods beginning not later than the first day of the fifth fiscal year which begins after fiscal year 1997, and not later than every 5 years thereafter, to reflect the most recent available data.

''(4) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term 'home health market basket percentage increase' means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the types of home health services described in subsection (a)(2) in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to inpatient hospital services for the fiscal year.

''(c) PER EPISODE LIMIT.—

''(1) AGGREGATE LIMIT.—

''(A) IN GENERAL.—Except as provided in paragraph (2), a home health agency may not receive aggregate per visit payments under subsection (a) for a fiscal year in excess of an amount equal to the sum of the following products determined for each case-mix category for which the agency receives payments:

''(i) The number of episodes of each case-mix category during the fiscal year; multiplied by

''(ii) the per episode limit determined for such case-mix category for such fiscal year.

''(B) ESTABLISHMENT OF PER EPISODE LIMITS.—

''(i) IN GENERAL.—The per episode limit for a fiscal year for any case-mix category for the area in which a home health agency is located is equal to—

''(I) the mean number of visits for each type of home health service described in subsection (a)(2) furnished during an episode of such case-mix category in such area during fiscal year 1994, adjusted by the case-mix adjustment factor determined in clause (ii) for the fiscal year involved; multiplied by

''(II) the per visit payment rate established under subsection (b) for such type of home health service for the fiscal year for which the determination is being made.

''(ii) CASE MIX ADJUSTMENT FACTOR.—For purposes of clause (i), the case-mix adjustment factor for a year is the factor determined by the Secretary to assure that aggregate payments for home health services under this section during the year will not exceed the payment for such services during the previous year as a result of changes in the number and type of home health visits within case-mix categories over the previous year.

''(iii) REBASING OF PER EPISODE AMOUNTS.—Beginning with fiscal year 1999 and every 2 years thereafter, the Secretary shall revise the mean number of home health visits determined under clause (i)(I) for each type of home health service visit described in subsection (a)(2) furnished during an episode in a case-mix category to reflect the most recently available data on the number of visits.

''(iv) DETERMINATION OF APPLICABLE AREA.—For purposes of determining per episode limits under this subparagraph, the area in which a home health agency is considered to be located shall be such area as the Secretary finds appropriate for purposes of this subparagraph.

''(C) CASE-MIX CATEGORY.—For purposes of this paragraph, the term 'case-mix category' means each of the 18 case-mix categories established under the Phase II Home Health Agency Prospective Payment Demonstration Project conducted by the Health Care Financing Administration. The Secretary may develop an alternate methodology for determining case-mix categories.

''(D) EPISODE.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'episode' means the continuous 120-day period that—

''(I) begins on the date of an individual's first visit for a type of home health service described in subsection (a)(2) for a case-mix category, and

''(II) is immediately preceded by a 60-day period in which the individual did not receive visits for a type of home health service described in subsection (a)(2).

''(ii) TREATMENT OF EPISODES SPANNING COST REPORTING PERIODS.—The Secretary shall provide for such rules as the Secretary considers appropriate regarding the treatment of episodes under this paragraph which begin during a cost reporting period and end in a subsequent cost reporting period.

''(E) EXEMPTIONS AND EXCEPTIONS.—The Secretary may provide for exemptions and exceptions to the limits established under this paragraph for a fiscal year as the Secretary deems appropriate, to the extent such exemptions and exceptions do not result in greater payments under this section than the exemptions and exceptions provided under section 1861(v)(1)(L)(ii) in fiscal year 1994, increased by the home health market basket percentage increase for the fiscal year involved (as defined in subsection (b)(4)).

''(2) RECONCILIATION OF AMOUNTS.—

''(A) OVERPAYMENTS TO HOME HEALTH AGENCIES.—Subject to subparagraph (B), if a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in excess of the amount determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall reduce payments under this section to the home health agency in the following fiscal year in such manner as the Secretary considers appropriate (including on an installment basis) to recapture the amount of such excess.

''(B) EXCEPTION FOR HOME HEALTH SERVICES FURNISHED OVER A PERIOD GREATER THAN 165 DAYS.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the amount of aggregate per visit payments determined under subsection (a) shall not include payments for home health visits furnished to an individual on or after a continuous period of more than 165 days after an individual begins an episode described in subsection (c)(1)(D) (if such period is not interrupted by the beginning of a new episode).

''(ii) REQUIREMENT OF CERTIFICATION.—Clause (i) shall not apply if the agency has not obtained a physician's certification with respect to the individual requiring such visits that includes a statement that the individual requires such continued visits, the reason for the need for such visits, and a description of such services furnished during such visits.

''(C) SHARE OF SAVINGS.—

''(i) BONUS PAYMENTS.—If a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in an amount less than the amount determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall pay such home health agency a bonus payment equal to 50 percent of the difference between such amounts in the following fiscal year, except that the bonus payment may not exceed 5 percent of the aggregate per visit payments made to the agency for the year.

''(ii) INSTALLMENT BONUS PAYMENTS.—The Secretary may make installment payments during a fiscal year to a home health agency based on the estimated bonus payment that the agency would be eligible to receive with respect to such fiscal year.

''(d) MEDICAL REVIEW PROCESS.—The Secretary shall implement a medical review process (with a particular emphasis on fiscal years 1997 and 1998) for the system of payments described in this section that shall provide an assessment of the pattern of care furnished to individuals receiving home health services for which payments are made under this section to ensure that such individuals receive appropriate home health services. Such review process shall focus on low-cost cases described in subsection (e)(3) and cases described in subsection (c)(2)(B) and shall require recertification by intermediaries at 30, 60, 90, 120, and 165 days into an episode described in subsection (c)(1)(D).

''(e) ADJUSTMENT OF PAYMENTS TO AVOID CIRCUMVENTION OF LIMITS.—

''(1) IN GENERAL.—The Secretary shall provide for appropriate adjustments to payments to home health agencies under this section to ensure that agencies do not circumvent the purpose of this section by—

''(A) discharging patients to another home health agency or similar provider;

''(B) altering corporate structure or name to avoid being subject to this section or for the purpose of increasing payments under this title; or

''(C) undertaking other actions considered unnecessary for effective patient care and intended to achieve maximum payments under this title.

''(2) TRACKING OF PATIENTS THAT SWITCH HOME HEALTH AGENCIES DURING EPISODE.—

''(A) DEVELOPMENT OF SYSTEM.—The Secretary shall develop a system that tracks home health patients that receive home health services described in subsection (a)(2) from more than 1 home health agency during an episode described in subsection (c)(1)(D).

''(B) ADJUSTMENT OF PAYMENTS.—The Secretary shall adjust payments under this section to each home health agency that furnishes an individual with a type of home health service described in subsection (a)(2) to ensure that aggregate payments on behalf of such individual during such episode do not exceed the amount that would be paid under this section if the individual received such services from a single home health agency.

''(3) LOW-COST CASES.—The Secretary shall develop a system designed to adjust payments to a home health agency for a fiscal year to eliminate any increase in growth of the percentage of low-cost episodes for which home health services are furnished by the agency over such percentage determined for the agency for the 12-month cost reporting period ending on June 30, 1994. The Secretary shall define a low-cost episode in a manner that provides that a home health agency has an incentive to be cost efficient in delivering home health services and that the volume of such services does not increase as a result of factors other than patient needs.

''(f) REPORT BY MEDICARE PAYMENT REVIEW COMMISSION.—During the first 3 years in which payments are made under this section, the Medicare Payment Review Commission shall annually submit a report to Congress on the effectiveness of the payment methodology established under this section that shall include recommendations regarding the following:

''(1) Case-mix and volume increases.

''(2) Quality monitoring of home health agency practices.

''(3) Whether a capitated payment for home care patients receiving care during a continuous period exceeding 165 days is warranted.

''(4) Whether public providers of service are adequately reimbursed.

''(5) The adequacy of the exemptions and exceptions to the limits provided under subsection (c)(1)(E).

''(6) The appropriateness of the methods provided under this section to adjust the per episode limits and annual payment updates to reflect changes in the mix of services, number of visits, and assignment to case categories to reflect changing patterns of home health care.

''(7) The geographic areas used to determine the per episode limits.

''(g) NO EFFECT ON NON-MEDICARE SERVICES.—Nothing in this section may be construed to affect the provision of or payment for home health services for which payment is not made under this title.''.

(b) PAYMENT FOR PROSTHETICS AND ORTHOTICS UNDER PART A.—Section 1814(k) (42 U.S.C. 1395f(k)) is amended—

(1) by inserting ''and prosthetics and orthotics'' after ''durable medical equipment''; and

(2) by inserting ''and 1834(h), respectively'' after ''1834(a)(1)''.

(c) CONFORMING AMENDMENTS.—

(1) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)), as amended by section 15522(b), is amended in the matter preceding paragraph (1) by striking ''1888 and 1888A'' and inserting ''1888, 1888A, and 1894''.

(2) TREATMENT OF ITEMS AND SERVICES PAID UNDER PART B.—

(A) PAYMENTS UNDER PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(i) by amending subparagraph (A) to read as follows:

''(A) with respect to home health services—

''(i) that are a type of home health service described in section 1894(a)(2), and which are furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, the amount determined under section 1894; or

''(ii) that are not described in clause (i) (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the lesser of—

''(I) the reasonable cost of such services, as determined under section 1861(v), or

''(II) the customary charges with respect to such services;''.

(ii) by striking ''and'' at the end of subparagraph (E);

(iii) by adding ''and'' at the end of subparagraph (F); and

(iv) by adding at the end the following new subparagraph:

''(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

''(i) the reasonable cost of such services, as determined under section 1861(v), or

''(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);''.

(B) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO AGENCY.—

(i) IN GENERAL.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)), as amended by section 15525(a)(1), is amended—

(I) by striking ''and (E)'' and inserting ''(E)''; and

(II) by striking the period at the end and inserting the following: '', and (F) in the case of types of home health services described in section 1894(a)(2) furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or otherwise).''.

(ii) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)), as amended by section 15525(a)(3), is amended by striking ''section 1842(b)(6)(E);'' and inserting ''subparagraphs (E) and (F) of section 1842(b)(6);''.

(C) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 15525(a)(2) and section 15609B(a), is amended—

(i) by striking ''or'' at the end of paragraph (16);

(ii) by striking the period at the end of paragraph (17) and inserting ''; or''; and

(iii) by adding at the end the following new paragraph:

''(18) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.''.

(3) SUNSET OF REASONABLE COST LIMITATIONS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following new clause:

''(iv) This subparagraph shall apply only to services furnished by home health agencies during cost reporting periods ending on or before September 30, 1996.''.

(d) LIMITATION ON PART A COVERAGE.—

(1) IN GENERAL.—Section 1812(a)(3) (42 U.S.C. 1395d(a)(3)) is amended by striking the semicolon and inserting ''for up to 165 days during any spell of illness;''.

(2) CONFORMING AMENDMENT.—Section 1812(b) (42 U.S.C. 1395d(b)) is amended—

(A) by striking ''or'' at the end of paragraph (2),

(B) by striking the period at the end of paragraph (3) and inserting ''; or'', and

(C) by adding at the end the following new paragraph:

''(4) home health services furnished to the individual during such spell after such services have been furnished to the individual for 165 days during such spell.''.

(3) EXCLUSION OF ADDITIONAL PART B COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

(A) in the second sentence of paragraph (1), by striking ''enrollees.'' and inserting ''enrollees (except as provided in paragraph (5)).''; and

(B) by adding at the end the following new paragraph:

''(5) In estimating the benefits and administrative costs which will be payable from the Federal Supplementary Medical Insurance Trust Fund for a year (beginning with 1996), the Secretary shall exclude an estimate of any benefits and costs attributable to home health services for which payment would have been made under part A during the year but for paragraph (4) of section 1812(b).''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to spells of illness beginning on or after October 1, 1995.

(e) EFFECTIVE DATE.—Except as provided in subsection (d)(4), the amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1996.

SEC. 15702. MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES.

(a) BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by adding at the end the following sentence: ''In establishing limits under this subparagraph, the Secretary may not take into account any changes in the costs of the provision of services furnished by home health agencies with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.''.

(b) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act.

SEC. 15703. EXTENSION OF WAIVER OF PRESUMPTION OF LACK OF KNOWLEDGE OF EXCLUSION FROM COVERAGE FOR HOME HEALTH AGENCIES.

Section 9305(g)(3) of OBRA–1986, as amended by section 426(d) of the Medicare Catastrophic Coverage Act of 1988 and section

4207(b)(3) of OBRA–1990 (as renumbered by section 160(d)(4) of the Social Security Act Amendments of 1994), is amended by striking ''December 31, 1995'' and inserting ''September 30, 1996''.

SEC. 15704. REPORT ON RECOMMENDATIONS FOR PAYMENTS AND CERTIFICATION FOR HOME HEALTH SERVICES OF CHRISTIAN SCIENCE PROVIDERS.

Not later than July 1, 1996, the Secretary of Health and Human Services shall submit recommendations to Congress regarding an appropriate methodology for making payments under the medicare program for home health services furnished by Christian Science providers who meet applicable requirements of the First Church of Christ, Scientist, Boston, Massachusetts, and appropriate criteria for the certification of such providers for purposes of the medicare program.

SEC. 15705. EXTENSION OF PERIOD OF HOME HEALTH AGENCY CERTIFICATION.

Section 1891(c)(2)(A) (42 U.S.C. 1395bbb(c)(2)(A)) is amended—

(1) by striking ''15 months'' and inserting ''36 months''; and

(2) by striking the second sentence and inserting the following: ''The Secretary shall establish a frequency for surveys of home health agencies within this 36-month interval commensurate with the need to assure the delivery of quality home health services.''.

PART 2—MEDICARE SECONDARY PAYER IMPROVEMENTS

SEC. 15711. EXTENSION AND EXPANSION OF EXISTING REQUIREMENTS.

(a) DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

(A) in clause (i), by striking ''clause (iv)'' and inserting ''clause (iii)'',

(B) by striking clause (iii), and

(C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by striking ''1862(b)(1)(B)(iv)'' each place it appears and inserting ''1862(b)(1)(B)(iii)''.

(c) EXPANSION OF PERIOD OF APPLICATION TO INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the first sentence, by striking ''12-month'' each place it appears and inserting ''24-month'', and

(2) by striking the second sentence.

SEC. 15712. IMPROVEMENTS IN RECOVERY OF PAYMENTS.

(a) PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS OF PRIMARY PLANS.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking ''under this subsection to pay'' and inserting ''(directly, as a third-party administrator, or otherwise) to make payment'', and

(2) by adding at the end the following: ''The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.''.

(b) EXTENSION OF CLAIMS FILING PERIOD.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

''(v) CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after the date of the enactment of this Act.

SEC. 15713. PROHIBITING RETROACTIVE APPLICATION OF POLICY REGARDING ESRD BENEFICIARIES ENROLLED IN PRIMARY PLANS.

For purposes of carrying out section 1862(b)(1)(C) of the Social Security Act, the Secretary of Health and Human Services shall apply the policy directive issued by the Administrator of the Health Care Financing Administration on April 24, 1995, only with respect to items and services furnished on or after such date.

PART 3—FAILSAFE

SEC. 15721. FAILSAFE BUDGET MECHANISM.

(a) IN GENERAL.—Title XVIII, as amended by sections 15106(a) and 15701(a), is amended by adding at the end the following new section:

''FAILSAFE BUDGET MECHANISM

''SEC. 1895. (a) REQUIREMENT OF PAYMENT ADJUSTMENTS TO ACHIEVE MEDICARE BUDGET TARGETS.—If the Secretary determines under subsection (e)(3)(C) before a fiscal year (beginning with fiscal year 1998) that—

''(1) the fee-for-service expenditures (as defined in subsection (f)) for a sector of medicare services (as defined in subsection (b)) for the fiscal year, will exceed

''(2) the allotment specified under subsection (c)(2) for such fiscal year (taking into account any adjustment in the allotment under subsection (h) for that fiscal year),

then, notwithstanding any other provision of this title, there shall be an adjustment (consistent with subsection (d)) in applicable payment rates or payments for items and services included in the sector in the fiscal year so that such expenditures for the sector for the year will be reduced by 133⅓ percent of the amount of such excess.

''(b) SECTORS OF MEDICARE SERVICES DESCRIBED.—

''(1) IN GENERAL.—For purposes of this section, items and services included under each of the following subparagraphs shall be considered to be a separate 'sector' of medicare services:

''(A) Inpatient hospital services.

''(B) Home health services.

''(C) Extended care services (for inpatients of skilled nursing facilities).

''(D) Hospice care.

''(E) Physicians' services (including services and supplies described in section 1861(s)(2)(A)) and services of other health care professionals (including certified registered nurse anesthetists, nurse practitioners, physician assistants, and clinical psychologists) for which separate payment is made under this title.

''(F) Outpatient hospital services and ambulatory facility services.

''(G) Durable medical equipment and supplies, including prosthetic devices and orthotics.

''(H) Diagnostic tests (including clinical laboratory services and x-ray services).

''(I) Other items and services.

''(2) CLASSIFICATION OF ITEMS AND SERVICES.—The Secretary shall classify each type of items and services covered and paid for separately under this title into one of the sectors specified in paragraph (1). After publication of such classification under subsection (e)(1), the Secretary is not authorized to make substantive changes in such classification.

''(c) ALLOTMENT.—

''(1) ALLOTMENTS FOR EACH SECTOR.—For purposes of this section, subject to subsection (h)(1), the allotment for a sector of medicare services for a fiscal year is equal to the product of—

''(A) the total allotment for the fiscal year established under paragraph (2), and

''(B) the allotment proportion (specified under paragraph (3)) for the sector and fiscal year involved.

''(2) TOTAL ALLOTMENT.—

''(A) IN GENERAL.—For purposes of this section, the total allotment for a fiscal year is equal to—

''(i) the medicare benefit budget for the fiscal year (as specified under subparagraph (B)), reduced by

''(ii) the amount of payments the Secretary estimates will be made in the fiscal year under the MedicarePlus program under part C.

In making the estimate under clause (ii), the Secretary shall take into account estimated enrollment and demographic profile of individuals electing MedicarePlus products.

''(B) MEDICARE BENEFIT BUDGET.—For purposes of this subsection, subject to subparagraph (C), the 'medicare benefit budget'—

''(i) for fiscal year 1997 is $208.0 billion;

''(ii) for fiscal year 1998 is $217.1 billion;

''(iii) for fiscal year 1999 is $228.4 billion;

''(iv) for fiscal year 2000 is $246.4 billion;

''(v) for fiscal year 2001 is $265.5 billion;

''(vi) for fiscal year 2002 is $288.0 billion; and

''(vii) for a subsequent fiscal year is equal to the medicare benefit budget under this subparagraph for the preceding fiscal year increased by the product of (I) 1.05, and (II) 1 plus the annual percentage increase in the average number of medicare beneficiaries from the previous fiscal year to the fiscal year involved.

''(3) MEDICARE ALLOTMENT PROPORTION DEFINED.—

''(A) IN GENERAL.—For purposes of this section and with respect to a sector of medicare services for a fiscal year, the term 'medicare allotment proportion' means the ratio of—

''(i) the baseline-projected medicare expenditures (as determined under subparagraph (B)) for the sector for the fiscal year, to

''(ii) the sum of such baseline expenditures for all such sectors for the fiscal year.

''(B) BASELINE-PROJECTED MEDICARE EXPENDITURES.—In this paragraph, the 'baseline, projected medicare expenditures' for a sector of medicare services—

''(i) for fiscal year 1996 is equal to fee-for-service expenditures for such sector during fiscal year 1995, increased by the baseline annual growth rate for such sector of medicare services for fiscal year 1996 (as specified in table in subparagraph (C)); and

''(ii) for a subsequent fiscal year is equal to the baseline-projected medicare expenditures under this subparagraph for the sector for the previous fiscal year increased by the baseline annual growth rate for such sector for the fiscal year involved (as specified in such table).

''(C) BASELINE ANNUAL GROWTH RATES.—The following table specifies the baseline annual growth rates for each of the sectors for different fiscal years:

''For the following sector—	Baseline annual growth rates for fiscal year—						
	1996	1997	1998	1999	2000	2001	2002 and thereafter
(A) Inpatient hospital services	5.7%	5.6%	6.0%	6.1%	5.7%	5.5%	5.2%
(B) Home health services	17.2%	15.1%	11.7%	9.1%	8.4%	8.1%	7.9%
(C) Extended care services	19.7%	12.3%	9.3%	8.7%	8.6%	8.4%	8.0%
(D) Hospice care	32.0%	24.0%	18.0%	15.0%	12.0%	10.0%	9.0%
(E) Physicians' services	12.4%	9.7%	8.7%	9.0%	9.3%	9.6%	10.1%
(F) Outpatient hospital services	14.7%	13.9%	14.5%	15.0%	14.1%	13.9%	14.0%
(G) Durable medical equipment and supplies	16.1%	15.5%	13.7%	12.4%	13.2%	13.9%	14.5%
(H) Diagnostic tests	13.1%	11.3%	11.0%	11.4%	11.4%	11.5%	11.9%
(I) Other items and services	11.2%	10.2%	10.9%	12.0%	11.6%	11.6%	11.8%

''(d) MANNER OF PAYMENT ADJUSTMENT.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall apply a payment reduction for a sector for a fiscal year in such a manner as to—

''(A) make a change in payment rates (to the maximum extent practicable) at the time payment rates are otherwise changed or subject to change for that fiscal year; and

''(B) provide for the full appropriate adjustment so that the fee-for-service expenditures for the sector for the fiscal year will approximate (and not exceed) the allotment for the sector for the fiscal year.

''(2) TAKING INTO ACCOUNT VOLUME AND CASH FLOW.—In providing for an adjustment in payments under this subsection for a sector for a fiscal year, the Secretary shall take into account (in a manner consistent with actuarial projections)—

''(A) the impact of such an adjustment on the volume or type of services provided in such sector (and other sectors), and

''(B) the fact that an adjustment may apply to items and services furnished in a fiscal year (payment for which may occur in a subsequent fiscal year),

in a manner that is consistent with assuring that total fee-for-services expenditures for each sector for the fiscal year will not exceed the allotment under subsection (c)(1) for such sector for such year.

''(3) PROPORTIONALITY OF REDUCTIONS WITHIN A SECTOR.—In making adjustments under this subsection in payment for items and services included within a sector of medicare services for a fiscal year, the Secretary shall provide for such an adjustment that results (to the maximum extent feasible) in the same percentage reductions in aggregate Federal payments under parts A and B for the different classes of items and services included within the sector for the fiscal year.

''(4) APPLICATION TO PAYMENTS MADE BASED ON PROSPECTIVE PAYMENT RATES DETERMINED ON A FISCAL YEAR BASIS.—

''(A) IN GENERAL.—In applying subsection (a) with respect to items and services for which payment is made under part A or B on the basis of rates that are established on a prospective basis for (and in advance of) a fiscal year, the Secretary shall provide for the payment adjustment under such subsection through an appropriate reduction in such rates established for items and services furnished (or, in the case of payment for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puerto Rico hospitals (as defined in paragraphs (1)(B) and (9)(A) of section 1886(d)), discharges occurring) during such year.

''(B) DESCRIPTION OF APPLICATION TO SPECIFIC SERVICES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

''(i) UPDATE FACTOR FOR PAYMENT FOR OPERATING COSTS OF INPATIENT HOSPITAL SERVICES OF PPS HOSPITALS.—To the computation of the applicable percentage increase specified in section 1886(d)(3)(B)(i) for discharges occurring in the fiscal year.

''(ii) HOME HEALTH SERVICES.—To the extent payment amounts for home health services are based on per visit payment rates under section 1894, to the computation of the increase in the national per visit payment rates established for the year under section 1894(b)(2)(B).

''(iii) HOSPICE CARE.—To the update of payment rates for hospice care under section 1814(i) for services furnished during the fiscal year.

''(iv) UPDATE FACTOR FOR PAYMENT OF OPERATING COSTS OF INPATIENT HOSPITAL SERVICES OF PPS-EXEMPT HOSPITALS.—To the computation of the target amount under section 1886(b)(3) for discharges occurring during the fiscal year.

''(v) COVERED NON-ROUTINE SERVICES OF SKILLED NURSING FACILITIES.—To the computation of the facility per stay limits for the year under section 1888A(d) for covered non-routine services of a skilled nursing facility (as described in such section).

''(5) APPLICATION TO PAYMENTS MADE BASED ON PROSPECTIVE PAYMENT RATES DETERMINED ON A CALENDAR YEAR BASIS.—

''(A) IN GENERAL.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on the basis of rates that are established on a prospective basis for (and in advance of) a calendar year, the Secretary shall provide for the payment adjustment under such subsection through an appropriate reduction in such rates established for items and services furnished at any time during such calendar year as follows:

''(i) For fiscal year 1997, the reduction shall be made for payment rates during calendar year 1997 in a manner so as to achieve the necessary payment reductions for such fiscal year for items and services furnished during the first 3 quarters of calendar year 1997.

''(ii) For a subsequent fiscal year, the reduction shall be made for payment rates during the calendar year in which the fiscal year ends in a manner so as to achieve the necessary payment reductions for such fiscal year for items and services furnished during the first 3 quarters of the calendar year, but also taking into account the payment reductions made in the first quarter of the fiscal year resulting from payment reductions made under this paragraph for the previous calendar year.

''(iii) Payment rate reductions effected under this subparagraph for a calendar year and applicable to the last 3 quarters of the fiscal year in which the calendar year ends shall continue to apply during the first quarter of the succeeding fiscal year.

''(B) APPLICATION IN SPECIFIC CASES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

''(i) UPDATE IN CONVERSION FACTOR FOR PHYSICIANS' SERVICES.—To the computation of the conversion factor under subsection (d) of section 1848 used in the fee schedule established under subsection (b) of such section, for items and services furnished during the calendar year in which the fiscal year ends.

''(ii) PAYMENT RATES FOR OTHER HEALTH CARE PROFESSIONALS.—To the computation of payments for professional services of certified registered nurse anesthetists under section 1833(l), nurse midwives, physician assistants, nurse practitioners and clinical nurse specialists under section 1833(r), clinical psychologists, clinical social workers, physical or occupational therapists, and any other health professionals for which payment rates are based (in whole or in part) on payments for physicians' services, for services furnished during the calendar year in which the fiscal year ends.

''(iii) UPDATE IN LAB FEE SCHEDULE.—To the computation of the fee schedule amount under section 1833(h)(2) for clinical diagnostic laboratory services furnished during the calendar year in which the fiscal year ends.

''(iv) UPDATE IN REASONABLE CHARGES FOR VACCINES.—To the computation of the reasonable charge for vaccines described in section 1861(s)(10) for vaccines furnished during the calendar year in which the fiscal year ends.

''(v) DURABLE MEDICAL EQUIPMENT-RELATED ITEMS.—To the computation of the payment basis under section 1834(a)(1)(B) for covered items described in section 1834(a)(13), for items furnished during the calendar year in which the fiscal year ends.

''(vi) RADIOLOGIST SERVICES.—To the computation of conversion factors for radiologist services under section 1834(b), for services furnished during the calendar year in which the fiscal year ends.

''(vii) SCREENING MAMMOGRAPHY.—To the computation of payment rates for screening mammography under section 1834(c)(1)(C)(ii), for screening mammography performed during the calendar year in which the fiscal year ends.

''(viii) PROSTHETICS AND ORTHOTICS.—To the computation of the amount to be recognized under section 1834(h) for payment for prosthetic devices and orthotics and prosthetics, for items furnished during the calendar year in which the fiscal year ends.

''(ix) SURGICAL DRESSINGS.—To the computation of the payment amount referred to in section 1834(i)(1)(B) for surgical dressings, for items furnished during the calendar year in which the fiscal year ends.

''(x) PARENTERAL AND ENTERAL NUTRITION.—To the computation of reasonable charge screens for payment for parenteral and enteral nutrition under section 1834(h), for nutrients furnished during the calendar year in which the fiscal year ends.

''(xi) AMBULANCE SERVICES.—To the computation of limits on reasonable charges for ambulance services, for services furnished during the calendar year in which the fiscal year ends.

''(6) APPLICATION TO PAYMENTS MADE BASED ON COSTS DURING A COST REPORTING PERIOD.—

''(A) IN GENERAL.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on the basis of costs incurred for items and services in a cost reporting period, the Secretary shall provide for the payment adjustment under such subsection for a fiscal year through an appropriate proportional reduction in the payment for costs for such items and services incurred at any time during each cost reporting period any part of which occurs during the fiscal year involved, but only (for each such cost reporting period) in the same proportion as the fraction of the cost reporting period that occurs during the fiscal year involved.

''(B) APPLICATION IN SPECIFIC CASES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

''(i) CAPITAL-RELATED COSTS OF HOSPITAL SERVICES.—To the computation of payment amounts for inpatient and outpatient hospital services under sections 1886(g) and 1861(v) for portions of cost reporting periods occurring during the fiscal year.

''(ii) OPERATING COSTS FOR PPS-EXEMPT HOSPITALS.—To the computation of payment amounts under section 1886(b) for operating costs of inpatient hospital services of PPS-exempt hospitals for portions of cost reporting periods occurring during the fiscal year.

''(iii) DIRECT GRADUATE MEDICAL EDUCATION.—To the computation of payment amounts under section 1886(h) for reasonable costs of direct graduate medical education costs for portions of cost reporting periods occurring during the fiscal year.

''(iv) INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—To the computation of payment amounts under section 1814(j) for inpatient rural primary care hospital services for portions of cost reporting periods occurring during the fiscal year.

''(v) EXTENDED CARE SERVICES OF A SKILLED NURSING FACILITY.—To the computation of payment amounts under section 1861(v) for post-hospital extended care services of a skilled nursing facility (other than covered non-routine services subject to section 1888A) for portions of cost reporting periods occurring during the fiscal year.

''(vi) REASONABLE COST CONTRACTS.—To the computation of payment amounts under section 1833(a)(1)(A) for organizations for portions of cost reporting periods occurring during the fiscal year.

''(vii) HOME HEALTH SERVICES.—Subject to paragraph (4)(B)(ii), for payment amounts for home health services, for portions of cost reporting periods occurring during such fiscal year.

''(7) OTHER.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on a basis not described in a previous paragraph of this subsection, the Secretary shall provide for the payment adjustment under such subsection through an appropriate proportional reduction in the payments (or payment bases for items and services furnished) during the fiscal year.

''(8) ADJUSTMENT OF PAYMENT LIMITS.—The Secretary shall provide for such proportional adjustment in any limits on payment established under part A or B for payment for items and services within a sector as may be appropriate based on (and in order to properly carry out) the adjustment on the amount of payment under this subsection in the sector.

''(9) REFERENCES TO PAYMENT RATES.—Except as the Secretary may provide, any reference in this title (other than this section) to a payment rate is deemed a reference to such a rate as adjusted under this subsection.

''(e) PUBLICATION OF DETERMINATIONS; JUDICIAL REVIEW.—

''(1) ONE-TIME PUBLICATION OF SECTORS AND GENERAL PAYMENT ADJUSTMENT METHODOLOGY.—Not later than October 1, 1996, the Secretary shall publish in the Federal Register the classification of medicare items and services into the sectors of medicare services under subsection (b) and the general methodology to be used in applying payment adjustments to the different classes of items and services within the sectors.

''(2) INCLUSION OF INFORMATION IN PRESIDENT'S BUDGET.—

''(A) IN GENERAL.—With respect to fiscal years beginning with fiscal year 1999, the President shall include in the budget submitted under section 1105 of title 31, United States Code, information on—

''(i) the fee-for-service expenditures, within each sector, for the second previous fiscal year, and how such expenditures compare to the adjusted sector allotment for that sector for that fiscal year; and

''(ii) actual annual growth rates for fee-for-service expenditures in the different sectors in the second previous fiscal year.

''(B) RECOMMENDATIONS REGARDING GROWTH FACTORS.—The President may include in such budget for a fiscal year (beginning with fiscal year 1998) recommendations regarding percentages that should be applied (for one or more fiscal years beginning with that fiscal year) instead of the baseline annual growth rates under subsection (c)(3)(C). Such recommendations shall take into account medically appropriate practice patterns.

''(3) DETERMINATIONS CONCERNING PAYMENT ADJUSTMENTS.—

''(A) RECOMMENDATIONS OF COMMISSION.—By not later than March 1 of each year (beginning with 1997), the Medicare Payment Review Commission shall submit to the Secretary and the Congress a report that analyzes the previous operation (if any) of this section and that includes recommendations concerning the manner in which this section should be applied for the following fiscal year.

''(B) PRELIMINARY NOTICE BY SECRETARY.—Not later than May 15 preceding the beginning of each fiscal year (beginning with fiscal year 1998), the Secretary shall publish in the Federal Register a notice containing the Secretary's preliminary determination, for each sector of medicare services, concerning the following:

''(i) The projected allotment under subsection (c) for such sector for the fiscal year.

''(ii) Whether there will be a payment adjustment for items and services included in such sector for the fiscal year under subsection (a).

''(iii) If there will be such an adjustment, the size of such adjustment and the methodology to be used in making such a payment adjustment for classes of items and services included in such sector.

''(iv) Beginning with fiscal year 1999, the fee-for-service expenditures for such sector for the second preceding fiscal year.

Such notice shall include an explanation of the basis for such determination. Determinations under this subparagraph and subparagraph (C) shall be based on the best data available at the time of such determinations.

''(C) FINAL DETERMINATION.—Not later than September 1 preceding the beginning of each fiscal year (beginning with fiscal year 1998), the Secretary shall publish in the Federal Register a final determination, for each sector of medicare services, concerning the matters described in subparagraph (B) and an explanation of the reasons for any differences between such determination and the preliminary determination for such fiscal year published under subparagraph (B).

''(4) LIMITATION ON ADMINISTRATIVE OR JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1878 or otherwise of—

''(A) the classification of items and services among the sectors of medicare services under subsection (b),

''(B) the determination of the amounts of allotments for the different sectors of medicare services under subsection (c),

''(C) the determination of the amount (or method of application) of any payment adjustment under subsection (d), or

''(D) any adjustment in an allotment effected under subsection (h).

''(f) FEE-FOR-SERVICE EXPENDITURES DEFINED.—In this section, the term 'fee-for-service expenditures', for items and services within a sector of medicare services in a fiscal year, means amounts payable for such items and services which are furnished during the fiscal year, and—

''(1) includes types of expenses otherwise reimbursable under parts A and B (including administrative costs incurred by organizations described in sections 1816 and 1842) with respect to such items and services, and

''(2) does not include amounts paid under part C.

''(g) EXPEDITED PROCESS FOR ADJUSTMENT OF SECTOR GROWTH RATES.—

''(1) OPTIONAL INCLUSION OF LEGISLATIVE PROPOSAL.—The President may include in recommendations under subsection (e)(2)(B) submitted with respect to a fiscal year a specific legislative proposal that provides only for the substitution of percentages specified in the proposal for one or more of the baseline annual growth rates (specified in the table in subsection (c)(3)(C) or in a previous legislative proposal under this subsection) for that fiscal year or any subsequent fiscal year.

''(2) CONGRESSIONAL CONSIDERATION.—

''(A) IN GENERAL.—The percentages contained in a legislative proposal submitted under paragraph (1) shall apply under this section if a joint resolution (described in subparagraph (B)) approving such proposal is enacted, in accordance with the provisions of subparagraph (C), before the end of the 60-day period beginning on the date on which such proposal was submitted. For purposes of applying the preceding sentence and subparagraphs (B) and (C), the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

''(B) JOINT RESOLUTION OF APPROVAL.—A joint resolution described in this subparagraph means only a joint resolution which is introduced within the 10-day period beginning on the date on which the President submits a proposal under paragraph (1) and—

''(i) which does not have a preamble;

''(ii) the matter after the resolving clause of which is as follows: 'That Congress approves the proposal of the President providing for substitution of percentages for certain baseline annual growth rates under section 1895 of the Social Security Act, as submitted by the President on _____.', the blank space being filled in with the appropriate date; and

''(iii) the title of which is as follows: 'Joint resolution approving Presidential proposal to substitute certain specified percentages for baseline annual growth rates under section 1895 of the Social Security Act, as submitted by the President on _____.', the blank space being filled in with the appropriate date.

''(C) PROCEDURES FOR CONSIDERATION OF RESOLUTION OF APPROVAL.—Subject to subparagraph (D), the provisions of section 2908

(other than subsection (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply to the consideration of a joint resolution described in subparagraph (B) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

''(D) SPECIAL RULES.—For purposes of applying subparagraph (C) with respect to such provisions—

''(i) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of a legislative proposal under paragraph (1)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to the Committee on Finance of the Senate;

''(ii) any reference to a resolution of which a committee shall be discharged from further consideration shall be deemed to be a reference to the first such resolution introduced; and

''(iii) any reference to the date on which the President transmits a report shall be deemed a reference to the date on which the President submits the legislative proposal under paragraph (1).

''(h) LOOK-BACK ADJUSTMENT IN ALLOTMENTS TO REFLECT ACTUAL EXPENDITURES.—

''(1) IN GENERAL.—If the Secretary determines under subsection (e)(3)(B) with respect to a particular fiscal year (beginning with fiscal year 1999) that the fee-for-service expenditures for a sector of medicare services for the second preceding fiscal year—

''(A) exceeded the adjusted allotment for such sector for such year (as defined in paragraph (2)), then the allotment for the sector for the particular fiscal year shall be reduced by 133⅓ percent of the amount of such excess, or

''(B) was less than the adjusted allotment for such sector for such year, then the allotment for the sector for the particular fiscal year shall be increased by the amount of such deficit.

''(2) ADJUSTED ALLOTMENT.—The adjusted allotment under this paragraph for a sector for a fiscal year is—

''(A) the amount that would be computed as the allotment under subsection (c) for the sector for the fiscal year if the actual amount of payments made in the fiscal year under the MedicarePlus program under part C in the fiscal year were substituted for the amount described in subsection (c)(2)(A)(ii) for that fiscal year,

''(B) adjusted to take into account the amount of any adjustment under paragraph (1) for that fiscal year (based on expenditures in the second previous fiscal year).

''(i) PROSPECTIVE APPLICATION OF CERTAIN NATIONAL COVERAGE DETERMINATIONS.—In the case of a national coverage determination that the Secretary projects will result in significant additional expenditures under this title (taking into account any substitution for existing procedures or technologies), such determination shall not become effective before the beginning of the fiscal year that begins after the date of such determination and shall apply to contracts under part C entered into (or renewed) after the date of such determination.''.

(b) REPORT OF TRUSTEES ON GROWTH RATE IN PART A EXPENDITURES.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(k) Each annual report provided in subsection (b)(2) shall include information regarding the annual rate of growth in program expenditures that would be required to maintain the financial solvency of the Trust Fund and the extent to which the provisions of section 1895 restrain the rate of growth of expenditures under this part in order to achieve such solvency.''.

PART 4—ADMINISTRATIVE SIMPLIFICATION

SEC. 15731. STANDARDS FOR MEDICARE INFORMATION TRANSACTIONS AND DATA ELEMENTS.

Title XVIII, as amended by section 15031, is amended by inserting after section 1806 the following new section:

''STANDARDS FOR MEDICARE INFORMATION TRANSACTIONS AND DATA ELEMENTS

''SEC. 1807. (a) ADOPTION OF STANDARDS FOR DATA ELEMENTS.—

''(1) IN GENERAL.—Pursuant to subsection (b), the Secretary shall adopt standards for information transactions and data elements of medicare information and modifications to the standards under this section that are—

''(A) consistent with the objective of reducing the administrative costs of providing and paying for health care; and

''(B) developed or modified by a standard setting organization (as defined in subsection (h)(8)).

''(2) SPECIAL RULE RELATING TO DATA ELEMENTS.—The Secretary may adopt or modify a standard relating to data elements that is different from the standard developed by a standard setting organization, if—

''(A) the different standard or modification will substantially reduce administrative costs to health care providers and health plans compared to the alternative; and

''(B) the standard or modification is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

''(3) SECURITY STANDARDS FOR HEALTH INFORMATION NETWORK.—

''(A) IN GENERAL.—Each person, who maintains or transmits medicare information or data elements of medicare information and is subject to this section, shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

''(i) to ensure the integrity and confidentiality of the information;

''(ii) to protect against any reasonably anticipated—

''(I) threats or hazards to the security or integrity of the information; and

''(II) unauthorized uses or disclosures of the information; and

''(iii) to otherwise ensure compliance with this section by the officers and employees of such person.

''(B) SECURITY STANDARDS.—The Secretary shall establish security standards and modifications to such standards with respect to medicare information network services, health plans, and health care providers that—

''(i) take into account—

''(I) the technical capabilities of record systems used to maintain medicare information;

''(II) the costs of security measures;

''(III) the need for training persons who have access to medicare information; and

''(IV) the value of audit trails in computerized record systems; and

''(ii) ensure that a medicare information network service, if it is part of a larger organization, has policies and security procedures which isolate the activities of such service with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

The security standards established by the Secretary shall be based on the standards developed or modified by standard setting organizations. If such standards do not exist, the Secretary shall rely on the recommendations of the Medicare Information Advisory Committee (established under subsection (g)) and shall consult with appropriate government agencies and private organizations in accordance with paragraph (5).

''(4) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for implementing each of the standards and the modifications to the standards adopted pursuant to paragraph (1) or (3).

''(5) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this section, the Secretary shall rely on recommendations of the Medicare Information Advisory Committee established under subsection (g) and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register the recommendations of the Medicare Information Advisory Committee regarding the adoption of a standard under this section.

''(b) STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS.—

''(1) IN GENERAL.—The Secretary shall adopt standards for transactions and data elements to make medicare information uniformly available to be exchanged electronically, that is—

''(A) appropriate for the following financial and administrative transactions: claims (including coordination of benefits) or equivalent encounter information, enrollment and disenrollment, eligibility, premium payments, and referral certification and authorization; and

''(B) related to other financial and administrative transactions determined appropriate by the Secretary consistent with the goals of improving the operation of the health care system and reducing administrative costs.

''(2) UNIQUE HEALTH IDENTIFIERS.—

''(A) ADOPTION OF STANDARDS.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the medicare information system. In developing unique health identifiers for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

''(B) PENALTY FOR IMPROPER DISCLOSURE.—A person who knowingly uses or causes to be used a unique health identifier under subparagraph (A) for a purpose that is not authorized by the Secretary shall—

''(i) be fined not more than $50,000, imprisoned not more than 1 year, or both; or

''(ii) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both.

''(3) CODE SETS.—

''(A) IN GENERAL.—The Secretary, in consultation with the Medicare Information Advisory Committee, experts from the private sector, and Federal and State agencies, shall—

''(i) select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

''(ii) establish code sets for such data elements if no code sets for the data elements have been developed.

''(B) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under subsection (c)(2).

''(4) ELECTRONIC SIGNATURE.—

''(A) IN GENERAL.—The Secretary, after consultation with the Medicare Information

Advisory Committee, shall promulgate regulations specifying procedures for the electronic transmission and authentication of signatures, compliance with which will be deemed to satisfy Federal and State statutory requirements for written signatures with respect to information transactions required by this section and written signatures on enrollment and disenrollment forms.

''(B) PAYMENTS FOR SERVICES AND PREMIUMS.—Nothing in this section shall be construed to prohibit the payment of health care services or health plan premiums by debit, credit, payment card or numbers, or other electronic means.

''(5) TRANSFER OF INFORMATION BETWEEN HEALTH PLANS.—The Secretary shall develop rules and procedures—

''(A) for determining the financial liability of health plans when health care benefits are payable under two or more health plans; and

''(B) for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

''(6) COORDINATION OF BENEFITS.—If, at the end of the 5-year period beginning on the date of the enactment of this section, the Secretary determines that additional transaction standards for coordinating benefits are necessary to reduce administrative costs or duplicative (or inappropriate) payment of claims, the Secretary shall establish further transaction standards for the coordination of benefits between health plans.

''(7) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, the standards adopted under this section shall not require disclosure of trade secrets or confidential commercial information by an entity operating a medicare information network.

''(c) TIMETABLES FOR ADOPTION OF STANDARDS.—

''(1) INITIAL STANDARDS.—Not later than 18 months after the date of the enactment of this section, the Secretary shall adopt standards relating to the information transactions, data elements of medicare information and security described in subsections (a) and (b).

''(2) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

''(A) IN GENERAL.—The Secretary shall review the standards adopted under this section and shall adopt additional or modified standards, that have been developed or modified by a standard setting organization, as determined appropriate, but not more frequently than once every 12 months. Any addition or modification to such standards shall be completed in a manner which minimizes the disruption and cost of compliance.

''(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

''(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

''(ii) ADDITIONAL RULES.—If a code set is modified under this paragraph, the modified code set shall include instructions on how data elements of medicare information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set under this paragraph shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

''(d) REQUIREMENTS FOR HEALTH PLANS.—

''(1) IN GENERAL.—If a person desires to conduct any of the information transactions described in subsection (b)(1) with a health plan as a standard transaction, the health plan shall conduct such standard transaction in a timely manner and the information transmitted or received in connection with such transaction shall be in the form of standard data elements of medicare information.

''(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirement imposed on such plan under paragraph (1) by directly transmitting standard data elements of medicare information or submitting nonstandard data elements to a medicare information network service for processing into standard data elements and transmission.

''(3) TIMETABLES FOR COMPLIANCE WITH REQUIREMENTS.—Not later than 24 months after the date on which standards are adopted under subsections (a) and (b) with respect to any type of information transaction or data element of medicare information or with respect to security, a health plan shall comply with the requirements of this section with respect to such transaction or data element.

''(4) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modified standard under subsection (a) or (b), a health plan shall be required to comply with the modified standard at such time as the Secretary determines appropriate taking into account the time needed to comply due to the nature and extent of the modification. However, the time determined appropriate under the preceding sentence shall be not earlier than the last day of the 180-day period beginning on the date such modified standard is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines such extension is appropriate.

''(e) GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.—

''(1) GENERAL PENALTY.—

''(A) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall impose on any person that violates a requirement or standard—

''(i) with respect to medicare information transactions, data elements of medicare information, or security imposed under subsection (a) or (b); or

''(ii) with respect to health plans imposed under subsection (d);

a penalty of not more than $100 for each such violation of a specific standard or requirement, but the total amount imposed for all such violations of a specific standard or requirement during the calendar year shall not exceed $25,000.

''(B) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this paragraph in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

''(C) DENIAL OF PAYMENT.—Except as provided in paragraph (2), the Secretary may deny payment under this title for an item or service furnished by a person if the person fails to comply with an applicable requirement or standard for medicare information relating to that item or service.

''(2) LIMITATIONS.—

''(A) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under paragraph (1) if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person failed to comply with the requirement or standard described in paragraph (1).

''(B) FAILURES DUE TO REASONABLE CAUSE.—

''(i) IN GENERAL.—Except as provided in clause (ii), a penalty may not be imposed under paragraph (1) if—

''(I) the failure to comply was due to reasonable cause and not to willful neglect; and

''(II) the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

''(ii) EXTENSION OF PERIOD.—

''(I) NO PENALTY.—The period referred to in clause (i)(II) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

''(II) ASSISTANCE.—If the Secretary determines that a health plan failed to comply because such plan was unable to comply, the Secretary may provide technical assistance to such plan during the period described in clause (i)(II). Such assistance shall be provided in any manner determined appropriate by the Secretary.

''(C) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under paragraph (1) that is not entirely waived under subparagraph (B) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

''(f) EFFECT ON STATE LAW.—

''(1) GENERAL EFFECT.—

''(A) GENERAL RULE.—Except as provided in subparagraph (B), a provision, requirement, or standard under this section shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

''(B) EXCEPTIONS.—A provision, requirement, or standard under this section shall not supersede a contrary provision of State law if the Secretary determines that the provision of State law should be continued for any reason, including for reasons relating to prevention of fraud and abuse or regulation of controlled substances.

''(2) PUBLIC HEALTH REPORTING.—Nothing in this section shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

''(g) MEDICARE INFORMATION ADVISORY COMMITTEE.—

''(1) ESTABLISHMENT.—There is established a committee to be known as the Medicare Information Advisory Committee (in this subsection referred to as the 'committee').

''(2) DUTIES.—The committee shall—

''(A) advise the Secretary in the development of standards under this section; and

''(B) be generally responsible for advising the Secretary and the Congress on the status and the future of the medicare information network.

''(3) MEMBERSHIP.—

''(A) IN GENERAL.—The committee shall consist of 9 members of whom—

''(i) 3 shall be appointed by the President;

''(ii) 3 shall be appointed by the Speaker of the House of Representatives after consultation with the minority leader of the House of Representatives; and

''(iii) 3 shall be appointed by the President pro tempore of the Senate after consultation with the minority leader of the Senate.

The appointments of the members shall be made not later than 60 days after the date of the enactment of this section. The President shall designate 1 member as the Chair.

''(B) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction in the areas of information systems, information networking and integration, consumer

health, or health care financial management, and who possess the demonstrated capacity to discharge the duties imposed on the committee.

''(C) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of not more than 3 members expire at one time.

''(D) INITIAL MEETING.—Not later than 30 days after the date on which a majority of the members have been appointed, the committee shall hold its first meeting.

''(4) REPORTS.—Not later than 1 year after the date of the enactment of this section, and annually thereafter, the committee shall submit to Congress and the Secretary a report regarding—

''(A) the extent to which entities using the medicare information network are meeting the standards adopted under this section and working together to form an integrated network that meets the needs of its users;

''(B) the extent to which such entities are meeting the security standards established pursuant to this section and the types of penalties assessed for noncompliance with such standards;

''(C) any problems that exist with respect to implementation of the medicare information network; and

''(D) the extent to which timetables under this section are being met.

Reports made under this subsection shall be made available to health care providers, health plans, and other entities that use the medicare information network to exchange medicare information.

''(h) DEFINITIONS.—For purposes of this section:

''(1) CODE SET.—The term 'code set' means any set of codes used for encoding data elements, such as tables of terms, enrollment information, and encounter data.

''(2) COORDINATION OF BENEFITS.—The term 'coordination of benefits' means determining and coordinating the financial obligations of health plans when health care benefits are payable under such a plan and under this title (including under a MedicarePlus product).

''(3) MEDICARE INFORMATION.—The term 'medicare information' means any information that relates to the enrollment of individuals under this title (including information relating to elections of MedicarePlus products under section 1805) and the provision of health benefits (including benefits provided under such products) under this title.

''(4) MEDICARE INFORMATION NETWORK.—The term 'medicare information network' means the medicare information system that is formed through the application of the requirements and standards established under this section.

''(5) MEDICARE INFORMATION NETWORK SERVICE.—The term 'medicare information network service' means a public or private entity that—

''(A) processes or facilitates the processing of nonstandard data elements of medicare information into standard data elements;

''(B) provides the means by which persons may meet the requirements of this section; or

''(C) provides specific information processing services.

''(6) HEALTH PLAN.—The term 'health plan' means a plan which provides, or pays the cost of, health benefits. Such term includes the following, or any combination thereof:

''(A) Part A or part B of this title, and includes a MedicarePlus product.

''(B) The medicaid program under title XIX and the MediGrant program under title XXI.

''(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

''(D) Worker's compensation or similar insurance.

''(E) Automobile or automobile medical-payment insurance.

''(F) A long-term care policy, other than a fixed indemnity policy.

''(G) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

''(H) An employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), but only to the extent the plan is established or maintained for the purpose of providing health benefits.

''(7) INDIVIDUALLY IDENTIFIABLE MEDICARE INFORMATION.—The term 'individually identifiable medicare information' means medicare enrollment information, including demographic information collected from an individual, that—

''(A) is created or received by a health care provider, health plan, employer, or medicare information network service, and

''(B) identifies an individual.

''(8) STANDARD SETTING ORGANIZATION.—The term 'standard setting organization' means a standard setting organization accredited by the American National Standards Institute.

''(9) STANDARD TRANSACTION.—The term 'standard transaction' means, when referring to an information transaction or to data elements of medicare information, any transaction that meets the requirements and implementation specifications adopted by the Secretary under subsections (a) and (b).''.

PART 5—OTHER PROVISIONS RELATING TO PARTS A AND B

SEC. 15741. CLARIFICATION OF MEDICARE COVERAGE OF ITEMS AND SERVICES ASSOCIATED WITH CERTAIN MEDICAL DEVICES APPROVED FOR INVESTIGATIONAL USE.

(a) COVERAGE.—Nothing in title XVIII of the Social Security Act may be construed to prohibit coverage under part A or part B of the medicare program of items and services associated with the use of a medical device in the furnishing of inpatient hospital services (as defined for purposes of part A of the medicare program) solely on the grounds that the device is not an approved device, if—

(1) the device is an investigational device; and

(2) the device is used instead of an approved device.

(b) CLARIFICATION OF PAYMENT AMOUNT.—Notwithstanding any other provision of title XVIII of the Social Security Act, the amount of payment made under the medicare program for any item or service associated with the use of an investigational device in the furnishing of inpatient hospital services (as defined for purposes of part A of the medicare program) may not exceed the amount of the payment which would have been made under the program for the item or service if the item or service were associated with the use of an approved device.

(c) DEFINITIONS.—In this section—

(1) the term ''approved device'' means a medical device which has been approved for marketing under pre-market approval under the Federal Food, Drug, and Cosmetic Act or cleared for marketing under a 510(k) notice under such Act; and

(2) the term ''investigational device'' means a medical device (other than a device described in paragraph (1)) which is approved for investigational use under section 520(g) of the Federal Food, Drug, and Cosmetic Act.

SEC. 15742. ADDITIONAL EXCLUSION FROM COVERAGE.

(a) IN GENERAL.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 15525(a)(2), section 15609B(a), and section 15701(c)(2)(C), is amended—

(1) by striking ''or'' at the end of paragraph (17),

(2) by striking the period at the end of paragraph (18) and inserting ''; or'', and

(3) by inserting after paragraph (18) the following new paragraph:

''(19) where such expenses are for items or services, or to assist in the purchase, in whole or in part, of health benefit coverage that includes items or services, for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payment for items and services furnished on or after the date of the enactment of this Act.

SEC. 15743. COMPETITIVE BIDDING FOR CERTAIN ITEMS AND SERVICES.

(a) ESTABLISHMENT OF DEMONSTRATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish and operate over a 2-year period a demonstration project in 2 geographic regions selected by the Secretary under which (notwithstanding any provision of title XVIII of the Social Security Act to the contrary) the amount of payment made under the medicare program for a selected item or service (other than clinical diagnostic laboratory tests) furnished in the region shall be equal to the price determined pursuant to a competitive bidding process which meets the requirements of subsection (b).

(b) REQUIREMENTS FOR COMPETITIVE BIDDING PROCESS.—The competitive bidding process used under the demonstration project under this section shall meet such requirements as the Secretary may impose to ensure the cost-effective delivery to medicare beneficiaries in the project region of items and services of high quality.

(c) DETERMINATION OF SELECTED ITEMS OR SERVICES.—The Secretary shall select items and services to be subject to the demonstration project under this section if the Secretary determines that the use of competitive bidding with respect to the item or service under the project will be appropriate and cost-effective. In determining the items or services to be selected, the Secretary shall consult with an advisory taskforce which includes representatives of providers and suppliers of items and services (including small business providers and suppliers) in each geographic region in which the project will be effective.

SEC. 15744. DISCLOSURE OF CRIMINAL CONVICTIONS RELATING TO PROVISION OF HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following new subsection:

''(g) The Secretary, and each State or local survey agency or other State agency responsible for monitoring compliance of home health agencies with requirements, shall make available, upon request of any person, information the Secretary or agency has on individuals who have been convicted of felonies relating to the provision of home health services.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 15745. REQUIRING RENAL DIALYSIS FACILITIES TO MAKE SERVICES AVAILABLE ON A 24-HOUR BASIS.

(a) IN GENERAL.—Section 1881(b)(1) (42 U.S.C. 1395rr(b)(1)) is amended by striking the period at the end and inserting the following: '', together with a requirement (in the case of a renal dialysis facility) that the facility make institutional dialysis services and supplies available on a 24-hour basis (either directly or through arrangements with

providers of services or other renal dialysis facilities that meet the requirements of such subparagraph) and that the facility provide notice informing its patients of the other providers of services or renal dialysis facilities (if any) with whom the facility has made such arrangements.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 1996.

Subtitle I—Clinical Laboratories

SEC. 15801. EXEMPTION OF PHYSICIAN OFFICE LABORATORIES.

Section 353(d) of the Public Health Service Act (42 U.S.C. 263a(d)) is amended—

(1) by redesignating paragraphs (2), (3), and (4) as paragraphs (3), (4), and (5) and by adding after paragraph (1) the following:

''(2) EXEMPTION OF PHYSICIAN OFFICE LABORATORIES.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a clinical laboratory in a physician's office (including an office of a group of physicians) which is directed by a physician and in which examinations and procedures are either performed by a physician or by individuals supervised by a physician solely as an adjunct to other services provided by the physician's office is exempt from this section.

''(B) EXCEPTION.—A clinical laboratory described in subparagraph (A) is not exempt from this section when it performs a pap smear (Papanicolaou Smear) analysis.

''(C) DEFINITION.—For purposes of subparagraph (A), the term 'physician' has the same meaning as is prescribed for such term by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).'';

(2) in paragraph (3) (as so redesignated) by striking ''(3)'' and inserting ''(4)''; and

(3) in paragraphs (4) and (5) (as so redesignated) by striking ''(2)'' and inserting ''(3)''.

Subtitle J—Lock-Box Provisions for Medicare Part B Savings from Growth Reductions

SEC. 15901. ESTABLISHMENT OF MEDICARE GROWTH REDUCTION TRUST FUND FOR PART B SAVINGS.

Part B of title XVIII is amended by inserting after section 1841 the following new section:

''MEDICARE GROWTH REDUCTION TRUST FUND

''SEC. 1841A. (a)(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Medicare Growth Reduction Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts appropriated under paragraph (2).

''(2) There are hereby appropriated to the Trust Fund, out of any amounts in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the Secretary's estimate of the reductions in outlays under this part that are attributable to the Medicare Preservation Act of 1995. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund.

''(3)(A) Subject to subparagraph (B), with respect to monies transferred to the Trust Fund, no transfers, authorizations of appropriations, or appropriations are permitted.

''(B) Beginning with fiscal year 2003, the Secretary may expend funds in the Trust Fund to carry out this title, but only to the extent provided by Congress in advance through a specific amendment to this section.

''(b) The provisions of subsections (b) through (e) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund, except that the Board of Trustees and Managing Trustee of the Trust Fund shall be composed of the members of the Board of Trustees and the Managing Trustee, respectively, of the Federal Supplementary Medical Insurance Trust Fund.''.

H.R. 2425

OFFERED BY: MR. GIBBONS

(Amendment in the Nature of a Substitute)

AMENDMENT NO. 2: Strike all after the enacting clause and insert the following:

TITLE XV—MEDICARE

SEC. 15000. SHORT TITLE OF TITLE; AMENDMENTS AND REFERENCES TO OBRA; TABLE OF CONTENTS OF TITLE.

(a) SHORT TITLE.—This title may be cited as the ''Medicare Enhancement Act of 1995''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) REFERENCES TO OBRA.—In this title, the terms ''OBRA–1986'', ''OBRA–1987'', ''OBRA–1989'', ''OBRA–1990'', and ''OBRA–1993'' refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

(d) TABLE OF CONTENTS OF TITLE.—The table of contents of this title is as follows:

Subtitle A—Provisions Relating to Medicare Part A

SEC. 15001. REDUCTIONS IN INFLATION UPDATES FOR INPATIENT HOSPITAL SERVICES.

(a) PPS HOSPITALS.—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended by striking subclauses (XI), (XII), and (XIII) and inserting the following:

''(XI) for each of the fiscal years 1996 through 2002, the market basket percentage increase minus 0.5 percentage point for hospitals located in a rural area and the market

basket percentage increase minus 1.0 percentage point for all other hospitals, and

''(XII) for fiscal year 2003 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.''.

(b) PPS-EXEMPT HOSPITALS.—Section 1886(b)(3)(B)(ii) (42 U.S.C. 1395ww(b)(3)(B)(ii)) is amended—

(1) in subclause (V)—

(A) by striking ''thorugh 1997'' and inserting ''through 1995'', and

(B) by striking ''and'' at the end;

(2) by redesignating subclause (VI) as subclause (VII); and

(3) by inserting after subclause (V) the following new subclause:

''(VI) fiscal years 1996 through 2002, is the market basket percentage increase minus 0.5 percentage point for hospitals located in a rural area and the market basket percentage increase minus 1.0 percentage point for all other hospitals, and''.

SEC. 15002. CONTINUATION OF CURRENT REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.

(a) REDUCTION IN PAYMENTS FOR PPS HOSPITALS.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended in the second sentence by striking ''through 1995'' and inserting ''through 2002''.

(b) REDUCTION IN PAYMENTS FOR PPS-EXEMPT HOSPITALS.—Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

''(4)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services furnished during fiscal years 1996 through 2002 of a hospital which is not a subsection (d) hospital or a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 10 percent.

''(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1861(mm)(1)).''.

SEC. 15003. ELIMINATION OF CERTAIN ADDITIONAL PAYMENTS FOR OUTLIER CASES.

(a) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is amended—

(1) by striking ''the sum of''; and

(2) by striking ''and the amount paid to the hospital under subparagraph (A)''.

(b) DISPROPORTIONATE SHARE ADJUSTMENTS.—Section 1886(d)(5)(F)(ii)(I) (42 U.S.C. 1395ww(d)(5)(F)(ii)(I)) is amended—

(1) by striking ''the sum of''; and

(2) by striking ''and the amount paid to the hospital under subparagraph (A) for that discharge''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 1995.

SEC. 15004. CLARIFICATION OF TREATMENT OF TRANSFERS.

(a) IN GENERAL.—Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)(I)) is amended by adding at the end the following new clause:

''(iii) In making adjustments under clause (i) for transfer cases, the Secretary shall treat as a transfer any transfer to a hospital (without regard to whether or not the hospital is a subsection (d) hospital), a unit thereof, or a skilled nursing facility.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges occurring on or after October 1, 1995.

SEC. 15005. PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES.

Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following:

''(e) Notwithstanding any other provision of this title, the Secretary shall, for cost reporting periods beginning on or after October 1, 1996, provide for payment for routine costs of extended care services in accordance with a prospective payment system established by the Secretary, subject to the limitations in subsections (f) through (h).

''(f)(1) The amount of payment under subsection (e) shall be determined on a per diem basis.

''(2) The Secretary shall compute the routine costs per diem in a base year (determined by the Secretary) for each skilled nursing facility, and shall update the per diem rate on the basis of a market basket and other factors as the Secretary determines appropriate.

''(3) The per diem rate applicable to a skilled nursing facility may not exceed the following limits—

''(A) With respect to skilled nursing facilities located in rural areas, the limit shall be equal to 112 percent of the mean per diem routine costs in a base year (determined by the Secretary) for freestanding skilled nursing facilities located in rural areas within the same region, as updated by the same percentage determined under paragraph (2).

''(B) With respect to skilled nursing facilities located in urban areas, the limit shall be equal to 112 percent of the mean per diem routine costs in a base year (determined by the Secretary) for freestanding skilled nursing facilities located in urban areas within the same region, updated by the same percentage determined under paragraph (2).

''(g) In the case of a hospital-based skilled nursing facility or a skilled nursing facility receiving payment under subsection (d) as of the date of enactment of this provision, the amount of payment to the facility based on application of subsections (e) and (f) may not be less than the per diem rate applicable to the facility for routine costs on the date of enactment of this provision.

''(h) Notwithstanding any other provision of this title, the Secretary shall, for cost reporting periods beginning on or after October 1, 1998, provide for payment for all costs of extended care services (including routine service costs, ancillary costs, and capital-related costs) in accordance with a prospective payment system established by the Secretary. The Secretary shall adjust the payment amounts under this subsection in a manner to assure that the aggregate payments made under this subsection in a fiscal year result in a 5 percent reduction (as estimated by the Secretary) in the amount of payments that would otherwise have been made for such fiscal year.

''(i) The Secretary may provide for such exceptions as the Secretary determines appropriate to the amount of payment based on application of subsections (e) though (h).''

SEC. 15006. MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR SKILLED NURSING FACILITIES.

(a) BASING UPDATES TO PER DIEM COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—

(1) IN GENERAL.—The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by adding at the end the following: ''(except that such updates may not take into account any changes in the routine service costs of skilled nursing facilities occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995).''.

(2) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by paragraph (1) in making any adjustments pursuant to section 1888(c) of the Social Security Act.

(b) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Any change made by the Secretary of Health and Human Services in the amount of any prospective payment paid to a skilled nursing facility under section 1888(d) of the Social Security Act for cost reporting periods beginning on or after October 1, 1995, may not take into account any changes in the costs of services occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995.

Subtitle B—Provisions Relating to Medicare Part B

SEC. 15101. PAYMENT FOR PHYSICIANS' SERVICES.

(a) REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH CUMULATIVE EXPENDITURE TARGET.—Section 1848(f)(2) (42 U.S.C. 1395w@4(f)(2)) is amended to read as follows:

''(f) CUMULATIVE EXPENDITURE TARGET.—

''(1) SPECIFICATION OF TARGET.—

''(A) FISCAL YEAR 1996.—The cumulative expenditure target for all physicians' services and for each category of such services for fiscal year 1996 shall be equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for 1996 (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

''(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from fiscal year 1995 to fiscal year 1996,

''(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from fiscal year 1995 to fiscal year 1996, plus 2 percentage points, and

''(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services or of the category of physicians' services in fiscal year 1996 (compared with fiscal year 1995) which will result from changes in law, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d),

minus 1 and multiplied by 100.

''(B) SUBSEQUENT FISCAL YEARS.—The cumulative expenditure target for all physicians' services and for each category of physicians' services for fiscal year 1997 and each subsequent fiscal year shall be equal to the cumulative expenditure target determined under this paragraph for the previous fiscal year, increased by the product of—

''(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for the fiscal year involved (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

''(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from the previous fiscal year to the fiscal year involved,

''(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, plus 2 percentage points, and

''(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services or of the category of physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d)(3),

minus 1 and multiplied by 100.''.

''(2) EXCLUSION OF SERVICES FURNISHED TO PRIVATE PLAN ENROLLEES.—In this subsection, the term 'physicians' services' with respect to a fiscal year does not include services furnished to an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through enrollment with an eligible organization with a risk-sharing contract under section 1876.''.

(b) ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER CUMULATIVE EXPENDITURE TARGET.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w@4(d)(3)) is amended—

(A) by striking paragraph (2);

(B) by amending paragraph (3) to read as follows:

''(3) UPDATE.—

''(A) IN GENERAL.—Subject to subparagraph (E), for purposes of this section the update for a year (beginning with 1997) is equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100), and

''(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

''(B) UPDATE ADJUSTMENT FACTOR.—The 'update adjustment factor' for a year for a category of physicians' services is equal to the quotient of—

''(i) the difference between (I) the sum of the allowed expenditures for physicians' services in such category furnished during each of the years 1995 through the year involved and (II) the sum of the amount of actual expenditures for physicians' services furnished in such category during each of the years 1995 through the previous year; divided by

''(ii) the Secretary's estimate of allowed expenditures for physicians' services in such category furnished during the year.

''(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of subparagraph (B), allowed expenditures for physicians' services in a category of physicians' services shall be determined as follows (as estimated by the Secretary):

''(i) In the case of allowed expenditures for 1995, such expenditures shall be equal to actual expenditures for services furnished during the 12-month period ending with June of 1995.

''(ii) In the case of allowed expenditures for 1996 and each subsequent year, such expenditures shall be equal to allowed expenditures for the previous year, increased by the cumulative expenditure target under subsection (f) for the fiscal year which begins during the year.

''(D) DETERMINATION OF ACTUAL EXPENDITURES.—For purposes of subparagraph (B), the amount of actual expenditures for physicians' services in a category of physicians' services furnished during a year shall be equal to the amount of expenditures for such services during the 12-month period ending with June of the previous year.

''(E) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

''(i) greater than 103 percent of the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year; or

''(ii) less than 92.5 percent of the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year.''; and

(C) by adding at the end the following new paragraph:

''(4) REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—Not later than November 1 of each year (beginning with 1996), the Secretary shall transmit to the Congress a report that describes the update in the conversion factor for physicians' services (as defined in subsection (f)(3)(A)) in the following year.

''(B) COMMISSION REVIEW.—The Medicare Payment Review Commission shall review the report submitted under subparagraph (A) for a year and shall submit to the Congress, by not later than December 1 of the year, a report containing its analysis of the conversion factor for the following year.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to physicians' services furnished on or after January 1, 1997.

(c) ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1996.—Section 1848(d)(1) (42 U.S.C. 1395w@4(d)(1)) is amended—

(1) by redesignating subparagraph (C) as subparagraph (D); and

(2) by inserting after subparagraph (B) the following new subparagraph:

''(C) SPECIAL RULE FOR 1996.—For 1996, the conversion factor under this subsection shall be $34.60 for all physicians' services.''.

SEC. 15102. FREEZE IN UPDATES TO PAYMENT AMOUNTS FOR CERTAIN ITEMS AND SERVICES.

(a) CLINICAL DIAGNOSTIC LABORATORY TESTS.—Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV)) is amended striking ''1994 and 1995'' and inserting ''1994, 1995, 1996, and 1997''.

(b) DURABLE MEDICAL EQUIPMENT.—

(1) COVERED ITEMS.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(A) by striking ''and'' at the end of subparagraph (A);

(B) in subparagraph (B)—

(i) by striking ''a subsequent year'' and inserting ''1993, 1994, and 1995'', and

(ii) by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(C) for 1996 and 1997, 0 percentage points; and

''(D) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.''.

(2) ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A)(iii) (42 U.S.C. 1395m(h)(4)(A)(iii)) is amended by striking ''1994 and 1995'' and inserting ''1994, 1995, 1996, and 1997''.

(c) AMBULATORY SURGICAL CENTER SERVICES.—The Secretary of Health and Human Services shall not provide for any inflation update in the payment amounts under subparagraphs (A) and (B) of section 1833(i)(2) of the Social Security Act for fiscal years 1996 and 1997.

SEC. 15103. REDUCTION IN EFFECTIVE BENEFICIARY COINSURANCE RATE FOR CERTAIN HOSPITAL OUTPATIENT SERVICES.

(a) IN GENERAL.—

(1) AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(A) by striking ''of 80 percent''; and

(B) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(2) RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended—

(A) by striking ''of 80 percent''; and

(B) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) REDUCTION IN BENEFICIARY COINSURANCE RATE.—Section 1866(a)(2) (42 U.S.C. 1395cc(a)(2)) is amended by adding at the end the following new subparagraph:

''(E)(i) In the case of services furnished during a year for which the amount of payment under part B is determined under section 1833(i) or section 1833(n), clause (ii) of subparagraph (A) shall be applied by reducing '20 percent' by the percentage established for the year under clause (ii).

''(ii) The percentage established for a year under this clause shall be the percentage which, if applied for the year, will result in a reduction in projected total coinsurance payments under part B during the year in an amount equal to the Secretary's estimate of the reduction in expenditures under part B which would have occurred as a result of the enactment of section 15103(a) of the Medicare Enhancement Act of 1995 if this subparagraph were not in effect for the year.

''(iii) The Secretary shall establish and publish the percentage established for a year under this clause not later than October 1 preceding the year involved (or not later than December 1, 1995, in the case of the percentage established for 1996).''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to services furnished during portions of cost reporting periods occurring on or after January 1, 1996.

SEC. 15104. EXPANDING COVERAGE OF PREVENTIVE BENEFITS.

(a) PROVIDING ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 49.—Section 1834(c)(2)(A) (42 U.S.C. 1395m(c)(2)(A)) is amended—

(1) in clause (iv), by striking ''but under 65 years of age,''; and

(2) by striking clause (v).

(b) COVERAGE OF SCREENING PAP SMEAR AND PELVIC EXAMS.—

(1) COVERAGE OF PELVIC EXAM; INCREASING FREQUENCY OF COVERAGE OF PAP SMEAR.—Section 1861(nn) (42 U.S.C. 1395x(nn)) is amended—

(A) in the heading, by striking ''Smear'' and inserting ''Smear; Screening Pelvic Exam'';

(B) by striking ''(nn)'' and inserting ''(nn)(1)'';

(C) by striking ''3 years'' and all that follows and inserting ''3 years, or during the preceding year in the case of a woman described in paragraph (3).''; and

(D) by adding at the end the following new paragraphs:

''(2) The term 'screening pelvic exam' means an pelvic examination provided to a woman if the woman involved has not had such an examination during the preceding 3 years, or during the preceding year in the case of a woman described in paragraph (3), and includes a clinical breast examination.

''(3) A woman described in this paragraph is a woman who—

''(A) is of childbearing age and has not had a test described in this subsection during each of the preceding 3 years that did not indicate the presence of cervical cancer; or

''(B) is at high risk of developing cervical cancer (as determined pursuant to factors identified by the Secretary).''.

(2) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)), as amended by subsection (a)(2), is amended—

(A) by striking ''and (5)'' and inserting ''(5)''; and

(B) by striking the period at the end and inserting the following: '', and (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn)).''.

(3) CONFORMING AMENDMENTS.—(A) Section 1861(s)(14) (42 U.S.C. 1395x(s)(14)) is amended by inserting ''and screening pelvic exam'' after ''screening pap smear''.

(B) Section 1862(a)(1)(F) (42 U.S.C. 1395y(a)(1)(F)) is amended by inserting ''and screening pelvic exam'' after ''screening pap smear''.

(c) COVERAGE OF COLORECTAL SCREENING.—

(1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

''(d) FREQUENCY AND PAYMENT LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS, SCREENING FLEXIBLE SIGMOIDOSCOPIES, AND SCREENING COLONOSCOPY.—

''(1) FREQUENCY LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening fecal-occult blood test provided to an individual for the purpose of early detection of colon cancer if the test is performed—

''(A) in the case of an individual under 65 years of age, more frequently than is provided in a periodicity schedule established by the Secretary for purposes of this subparagraph; or

''(B) in the case of any other individual, within the 11 months following the month in which a previous screening fecal-occult blood test was performed.

''(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

''(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section 1848 with respect to screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

''(B) FREQUENCY LIMITS.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer if the procedure is performed—

''(i) in the case of an individual under 65 years of age, more frequently than is provided in a periodicity schedule established by the Secretary for purposes of this subparagraph; or

''(ii) in the case of any other individual, within the 59 months following the month in which a previous screening flexible sigmoidoscopy was performed.

''(3) SCREENING COLONOSCOPY FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.—

''(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section 1848 with respect to screening colonoscopy for individuals at high risk for colorectal cancer (as determined in accordance with criteria established by the Secretary) provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

''(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening colonoscopy for individuals at high risk for colorectal cancer provided to an individual for the purpose of early detection of colon cancer if the procedure is performed within the 47 months following the month in which a previous screening colonoscopy was performed.

''(C) FACTORS CONSIDERED IN ESTABLISHING CRITERIA FOR DETERMINING INDIVIDUALS AT HIGH RISK.—In establishing criteria for determining whether an individual is at high risk for colorectal cancer for purposes of this paragraph, the Secretary shall take into consideration family history, prior experience of cancer, a history of chronic digestive disease condition, and the presence of any appropriate recognized gene markers for colorectal cancer.

''(4) REVISION OF FREQUENCY.—

''(A) REVIEW.—The Secretary shall review periodically the appropriate frequency for performing screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy based on age and such other factors as the Secretary believes to be pertinent.

''(B) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which such tests and procedures may be paid for under this subsection.''.

(2) CONFORMING AMENDMENTS.—(A) Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by striking ''subsection (h)(1),'' and inserting ''subsection (h)(1) or section 1834(d)(1),''.

(B) Clauses (i) and (ii) of section 1848(a)(2)(A) (42 U.S.C. 1395w–4(a)(2)(A)) are each amended by striking ''a service'' and inserting ''a service (other than a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer or a screening colonoscopy provided to an individual at high risk for colorectal cancer for the purpose of early detection of colon cancer)''.

(C) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(i) in paragraph (1)—

(I) in subparagraph (E), by striking ''and'' at the end;

(II) in subparagraph (F), by striking the semicolon at the end and inserting '', and''; and

(III) by adding at the end the following new subparagraph:

''(G) in the case of screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy provided for the purpose of early detection of colon cancer, which are performed more frequently than is covered under section 1834(d);''; and

(ii) in paragraph (7), by striking ''paragraph (1)(B) or under paragraph (1)(F)'' and inserting ''subparagraphs (B), (F), or (G) of paragraph (1)''.

(d) PROSTATE CANCER SCREENING TESTS.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) by striking ''and'' at the end of subparagraph (N) and subparagraph (O); and

(B) by inserting after subparagraph (O) the following new subparagraph:

''(P) prostate cancer screening tests (as defined in subsection (oo)); and''.

(2) TESTS DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Prostate Cancer Screening Tests

''(oo) The term 'prostate cancer screening test' means a test that consists of a digital rectal examination or a prostate-specific antigen blood test (or both) provided for the purpose of early detection of prostate cancer to a man over 40 years of age who has not had such a test during the preceding year.''.

(3) PAYMENT FOR PROSTATE-SPECIFIC ANTIGEN BLOOD TEST UNDER CLINICAL DIAGNOSTIC LABORATORY TEST FEE SCHEDULES.—Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by inserting after ''laboratory tests'' the following: ''(including prostate cancer screening tests under section 1861(oo) consisting of prostate-specific antigen blood tests)''.

(4) CONFORMING AMENDMENT.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by subsection (c)(3)(C), is amended—

(A) in paragraph (1)—

(i) in subparagraph (F), by striking ''and'' at the end,

(ii) in subparagraph (G), by striking the semicolon at the end and inserting '', and'', and

(iii) by adding at the end the following new subparagraph:

''(H) in the case of prostate cancer screening test (as defined in section 1861(oo)) provided for the purpose of early detection of prostate cancer, which are performed more frequently than is covered under such section;''; and

(B) in paragraph (7), by striking ''or (G)'' and inserting ''(G), or (H)''.

(e) DIABETES SCREENING BENEFITS.—

(1) DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.—

(A) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by subsection (d)(1), is amended—

(i) by striking ''and'' at the end of subparagraph (N);

(ii) by striking ''and'' at the end of subparagraph (O); and

(iii) by inserting after subparagraph (O) the following new subparagraph:

''(P) diabetes outpatient self-management training services (as defined in subsection (pp)); and''.

(B) DEFINITION.—Section 1861 (42 U.S.C. 1395x), as amended by subsection (d)(2), is amended by adding at the end the following new subsection:

''DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES

''(pp)(1) The term 'diabetes outpatient self-management training services' means educational and training services furnished to an individual with diabetes by or under arrangements with a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity who meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

''(2) In paragraph (1)—

''(A) a 'certified provider' is an individual or entity that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this title; and

''(B) an individual or entity meets the quality standards described in this paragraph if the individual or entity meets quality standards established by the Secretary, except that the individual or entity shall be deemed to have met such standards if the individual or entity meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or is recognized by the American Diabetes Association as meeting standards for furnishing the services.''.

(C) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848(a) of the Social Security Act for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall

consult with appropriate organizations, including the American Diabetes Association, in determining the relative value for such services under section 1848(c)(2) of such Act.

(2) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH DIABETES.—

(A) INCLUDING STRIPS AS DURABLE MEDICAL EQUIPMENT.—Section 1861(n) (42 U.S.C. 1395x(n)) is amended by striking the semicolon in the first sentence and inserting the following: '', and includes blood-testing strips for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes (as determined under standards established by the Secretary in consultation with the American Diabetes Association);''.

(2) PAYMENT FOR STRIPS BASED ON METHODOLOGY FOR INEXPENSIVE AND ROUTINELY PURCHASED EQUIPMENT.—Section 1834(a)(2)(A) (42 U.S.C. 1395m(a)(2)(A)) is amended—

(A) by striking ''or'' at the end of clause (ii);

(B) by adding ''or'' at the end of clause (iii); and

(C) by inserting after clause (iii) the following new clause:

''(iv) which is a blood-testing strip for an individual with diabetes,''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1996.

SEC. 15105. REDUCTION IN PAYMENT FOR CAPITAL-RELATED COSTS OF HOSPITAL OUTPATIENT SERVICES.

Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking ''through 1998'' and inserting ''through 2002''.

SEC. 15106. PART B PREMIUM.

Section 1839(e)(1) (42 U.S.C. 1395r(e)(1)) is amended—

(1) in subparagraph (A), by striking ''1995'' and inserting ''1996'', and

(2) in subparagraph (B)(v), by inserting ''and 1996'' after ''1995''.

SEC. 15107. ENSURING PAYMENT FOR PHYSICIAN AND NURSE FOR JOINTLY FURNISHED ANESTHESIA SERVICES.

(a) PAYMENT FOR JOINTLY FURNISHED SINGLE CASE.—

(1) PAYMENT TO PHYSICIAN.—Section 1848(a)(4) (42 U.S.C. 1395w@4(a)(4)) is amended by adding at the end the following new subparagraph:

''(C) PAYMENT FOR SINGLE CASE.—Notwithstanding section 1862(a)(1)(A), with respect to physicians' services consisting of the furnishing of anesthesia services for a single case that are furnished jointly with a certified registered nurse anesthetist, if the carrier determines that the use of both the physician and the nurse anesthetist to furnish the anesthesia service was not medically necessary, the fee schedule amount for the physicians' services shall be equal to 50 percent (or 55 percent, in the case of services furnished during 1996 or 1997) of the fee schedule amount applicable under this section for anesthesia services personally performed by the physician alone (without regard to this subparagraph). Nothing in this subparagraph may be construed to affect the application of any provision of law regarding balance billing.''.

(2) PAYMENT TO CRNA.—Section 1833(l)(4)(B) (42 U.S.C. 1395l(l)(4)(B)) is amended by adding at the end the following new clause:

''(iv) Notwithstanding section 1862(a)(1)(A), in the case of services of a certified registered nurse anesthetist consisting of the furnishing of anesthesia services for a single case that are furnished jointly with a physician, if the carrier determines that the use of both the physician and the nurse anesthetist to furnish the anesthesia service was not medically necessary, the fee schedule amount for the services furnished by the certified registered nurse anesthetist shall be equal to 50 percent (or 40 percent, in the case of services furnished during 1996 or 1997) of the fee schedule amount applicable under section 1848 for anesthesia services personally performed by the physician alone (without regard to this clause).''.

(b) EFFECTIVE DATE.—The amendments made by subsections (a) shall apply to services furnished on or after July 1, 1996.

Subtitle C—Provisions Relating to Parts A and B

PART 1—MEDICARE SECONDARY PAYER

SEC. 15201. EXTENSION OF EXISTING SECONDARY PAYER REQUIREMENTS.

(a) DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

(A) in clause (i), by striking ''clause (iv)'' and inserting ''clause (iii)'',

(B) by striking clause (iii), and

(C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by striking ''1862(b)(1)(B)(iv)'' each place it appears and inserting ''1862(b)(1)(B)(iii)''.

(c) PERIOD OF APPLICATION TO INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the first sentence, by striking ''12-month'' each place it appears and inserting ''18-month'', and

(2) by striking the second sentence.

SEC. 15202. CLARIFICATION OF TIME AND FILING LIMITATIONS.

(a) IN GENERAL.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

''(v) TIME, FILING, AND RELATED PROVISIONS UNDER PRIMARY PLAN.—Requirements under a primary plan as to the filing of a claim, time limitations for the filing of a claim, information not maintained by the Secretary, or notification or pre-admission review, shall not apply to a claim by the United States under clause (ii) or (iii).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to items and services furnished after 1993.

SEC. 15203. CLARIFICATION OF LIABILITY OF THIRD PARTY–ADMINISTRATORS.

(a) IN GENERAL.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended by inserting '', or which determines claims under the primary plan'' after ''primary plan''.

(b) CLAIMS BETWEEN PARTIES OTHER THAN THE UNITED STATES.— Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)), (as amended by section 15201(a)) is further amended by adding at the end the following new clause:

''(vi) CLAIMS BETWEEN PARTIES OTHER THAN THE UNITED STATES.—A claim by the United States under clause (ii) or (iii) shall not preclude claims between other parties.''.

(c) EFFECTIVE DATE.—The amendments made by the previous subsections apply to items and services furnished after 1993.

SEC. 15204. CLARIFICATION OF PAYMENT AMOUNTS TO MEDICARE.

(a) IN GENERAL.—Section 1862(b)(2)(B)(i) (42 U.S.C. 1395y(b)(2)(B)(i)) is amended to read as follows:

''(i) REPAYMENT REQUIRED.—

''(I) Any payment under this title, with respect to any item or service for which payment by a primary plan is required under the preceding provisions of this subsection, shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for that item or service has been or should have been made under those provisions. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

''(II) The amount owed by a primary plan under the first sentence of subclause (I) is the lesser of the full primary payment required (if that amount is readily determinable) and the amount paid under this title for that item or service.''.

(b) CONFORMING AND TECHNICAL AMENDMENTS.—

(1) Subparagraphs (A)(i)(I) and (B)(i) of section 1862(b)(1) (42 U.S.C. 1395y(b)(1)) are each amended by inserting ''(or eligible to be covered)'' after ''covered''.

(2) Section 1862(b)(1)(C)(ii) (42 U.S.C. 1395y(b)(1)(C)(ii)) is amended by striking ''covered by such plan''.

(3) The matter in section 1861(b)(2)(A) (42 U.S.C. 1395x(b)(2)(A)) preceding clause (i) is amended by striking '', except as provided in subparagraph (B),''.

(c) EFFECTIVE DATE.—The amendments made by the previous subsections apply to items and services furnished after 1993.

SEC. 15205. CONDITIONS FOR DOUBLE DAMAGES.

(a) IN GENERAL.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking '', in accordance with paragraph (3)(A)'', and

(2) by inserting '', unless the entity demonstrates that it did not know, and could not have known, of its obligation to pay'' after ''against that entity''.

(b) CONFORMING AMENDMENT.—Section 1862(b)(3)(A) (42 U.S.C. 1395y(b)(3)(A)) is amended by striking ''(or appropriate reimbursement)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished after 1993.

PART 2—OTHER PROVISIONS RELATING TO PARTS A AND B

SEC. 15221. MAKING ADDITIONAL CHOICES OF HEALTH PLANS AVAILABLE TO BENEFICIARIES.

(a) DEFINITION OF PPO.—Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

''(k)(1) A preferred provider organization (as defined in paragraph (2)) shall be considered to be an eligible organization under this section.

''(2) In this section, the term 'preferred provider organization' means an organization that—

''(A) would be an eligible organization (as defined in subsection (b)) if—

''(i) clauses (ii) through (iv) of subsection (b)(2)(A) did not apply,

''(ii) subsection (b)(2)(C) did not apply, and

''(iii) subsection (b)(2)(D) only applied (in the case of services not provided under this title) to the physicians' services the organization provides; and

''(B) permits enrollees to obtain benefits through any lawful provider.

Nothing in subparagraph (B) shall be construed as requiring that the benefits for services provided through providers that do not

have a contract with the organization be the same as those for services provided through providers that have such contracts so long as an enrollee's liabilities do not exceed the liabilities that the enrollee would have under parts A and B if the individual were not enrolled under this section.''.

(b) PARTIAL RISK PAYMENT METHODS.—Section 1876 (42 U.S.C. 1395mm) is further amended by adding at the end the following new subsection:

''(l) Notwithstanding the previous provisions of this section, at the election of an eligible organization the Secretary may establish an alternative partial-risk-sharing mechanism for making payment to the organization under this section. Under such mechanism fee-for-service payments would be made to the organization for some services provided under the contract, under such conditions and subject to such restrictions as the Secretary may determine.''.

(c) CONFORMING AMENDMENT.—Section 1876 (42 U.S.C. 1395mm) is further amended—

(1) in the heading by striking ''ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS'' and inserting ''ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND PREFERRED PROVIDER ORGANIZATIONS'', and

(2) in subsection (c)(3)(E)(ii), by inserting ''(if any)'' after ''the restrictions''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to contract years beginning on or after January 1, 1996.

SEC. 15222. TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.

(a) TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.—The Social Security Act (42 U.S.C. 300 et seq.) is amended by adding at the end the following title:

''TITLE XXI—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

''PART A—ESTABLISHMENT OF FUND

''SEC. 2101. ESTABLISHMENT OF FUND.

''(a) IN GENERAL.—There is established in the Treasury of the United States a fund to be known as the Teaching Hospital and Graduate Medical Education Trust Fund (in this title referred to as the 'Fund'), consisting of amounts transferred to the Fund under subsection (c), amounts appropriated to the Fund pursuant to subsections (d) and (e)(3), and such gifts and bequests as may be deposited in the Fund pursuant to subsection (f). Amounts in the Fund are available until expended.

''(b) EXPENDITURES FROM FUND.—Amounts in the Fund are available to the Secretary for making payments under section 2111.

''(c) TRANSFERS TO FUND.—

''(1) IN GENERAL.—From the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the Secretary shall, for fiscal year 1996 and each subsequent fiscal year, transfer to the Fund an amount determined by the Secretary for the fiscal year involved in accordance with paragraph (2).

''(2) DETERMINATION OF AMOUNTS.—For purposes of paragraph (1), the amount determined under this paragraph for a fiscal year is an estimate by the Secretary of an amount equal to 75 percent of the difference between—

''(A) the nationwide total of the amounts that would have been paid under section 1876(a)(4) during the year but for the exclusion of medical education payments from the adjusted average per capita cost pursuant to section 1876(a)(4)(B)(ii); and

''(B) the nationwide total of the amounts paid under section 1876(a)(4) during the year.

''(3) ALLOCATION BETWEEN MEDICARE TRUST FUNDS.—In providing for a transfer under paragraph (1) for a fiscal year, the Secretary shall provide for an allocation of the amounts involved between part A and part B of title XVIII (and the trust funds established under the respective parts) as reasonably reflects the proportion of payments for the indirect costs of medical education and direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Fund such sums as may be necessary for each of the fiscal years 1996 through 2002.

''(e) INVESTMENT.—

''(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

''(2) SALE OF OBLIGATIONS.—Any obligation acquired by the Fund may be sold by the Secretary of the Treasury at the market price.

''(3) AVAILABILITY OF INCOME.—Any interest derived from obligations acquired by the Fund, and proceeds from any sale or redemption of such obligations, are hereby appropriated to the Fund.

''(f) ACCEPTANCE OF GIFTS AND BEQUESTS.—The Fund may accept on behalf of the United States money gifts and bequests made unconditionally to the Fund for the benefit of the Fund or any activity financed through the Fund.

''PART B—PAYMENTS TO TEACHING HOSPITALS

''SEC. 2111. FORMULA PAYMENTS TO TEACHING HOSPITALS.

''(a) IN GENERAL.—In the case of each teaching hospital that in accordance with subsection (b) submits to the Secretary a payment document for fiscal year 1996 or any subsequent fiscal year, the Secretary shall make payments for the year to the teaching hospital for the direct and indirect costs of operating approved medical residency training programs. Such payments shall be made from the Fund, and shall be made in accordance with a formula established by the Secretary.

''(b) PAYMENT DOCUMENT.—For purposes of subsection (a), a payment document is a document containing such information as may be necessary for the Secretary to make payments under such subsection to a teaching hospital for a fiscal year. The document is submitted in accordance with this subsection if the document is submitted not later than the date specified by the Secretary, and the document is in such form and is made in such manner as the Secretary may require. The Secretary may require that information under this subsection be submitted to the Secretary in periodic reports.''.

(b) NATIONAL ADVISORY COUNCIL ON POSTGRADUATE MEDICAL EDUCATION.—

(1) IN GENERAL.—There is established within the Department of Health and Human Services an advisory council to be known as the National Advisory Council on Postgraduate Medical Education (in this title referred to as the ''Council'').

(2) DUTIES.—The council shall provide advice to the Secretary on appropriate policies for making payments for the support of postgraduate medical education in order to assure an adequate supply of physicians trained in various specialities, consistent with the health care needs of the United States.

(3) COMPOSITION.—

(A) IN GENERAL.—The Secretary shall appoint to the Council 15 individuals who are not officers or employees of the United States. Such individuals shall include not less than 1 individual from each of the following categories of individuals or entities:

(i) Organizations representing consumers of health care services.

(ii) Physicians who are faculty members of medical schools, or who supervise approved physician training programs.

(iii) Physicians in private practice who are not physicians described in clause (ii).

(iv) Practitioners in public health.

(v) Advanced-practice nurses.

(vi) Other health professionals who are not physicians.

(vii) Medical schools.

(viii) Teaching hospitals.

(ix) The Accreditation Council on Graduate Medical Education.

(x) The American Board of Medical Specialities.

(xi) The Council on Postdoctoral Training of the American Osteopathic Association.

(xii) The Council on Podiatric Medical Education of the American Podiatric Medical Association.

(B) REQUIREMENTS REGARDING REPRESENTATIVE MEMBERSHIP.—To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States, shall reflect the racial, ethnic, and gender composition of the population of the United States, and shall be broadly representative of medical schools and teaching hospitals in the United States.

(C) EX OFFICIO MEMBERS; OTHER FEDERAL OFFICERS OR EMPLOYEES.—The membership of the Council shall include individuals designated by the Secretary to serve as members of the Council from among Federal officers or employees who are appointed by the President, or by the Secretary (or by other Federal officers who are appointed by the President with the advice and consent of the Senate). Individuals designated under the preceding sentence shall include each of the following officials (or a designee of the official):

(i) The Secretary of Health and Human Services.

(ii) The Secretary of Veterans Affairs.

(iii) The Secretary of Defense.

(4) CHAIR.—The Secretary shall, from among members of the council appointed under paragraph (3)(A), designate an individual to serve as the chair of the council.

(5) TERMINATION.—The Council terminates December 31, 1999.

(c) REMOVE MEDICAL EDUCATION AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

(1) IN GENERAL.—Section 1876(a)(4) (42 U.S.C. 1395mm(a)(4)) is amended—

(A) by striking ''(4)'' and inserting ''(4)(A)''; and

(B) by adding at the end the following new subparagraph:

''(B) In determining the adjusted average per capita cost for a contract year under subparagraph (A), the Secretary shall exclude any amounts which the Secretary estimates would be payable under this title during the year for—

''(i) payment adjustments under section 1886(d)(5)(F) for hospitals serving a disproportionate share of low-income patients; and

''(ii) the indirect costs of medical education under section 1886(d)(5)(B) or for direct graduate medical education costs under section 1886(h).''.

(2) PAYMENTS TO HOSPITALS OF AMOUNTS ATTRIBUTABLE TO DSH.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(j)(1) In addition to amounts paid under subsection (d)(5)(F), the Secretary is authorized to pay hospitals which are eligible for such payments for a fiscal year supplemental amounts that do not exceed the limit provided for in paragraph (2).

''(2) The sum of the aggregate amounts paid pursuant to paragraph (1) for a fiscal year shall not exceed the Secretary's estimate of 75 percent of the amount excluded from the adjusted average per capita cost for the fiscal year pursuant to section 1876(a)(4)(B)(i).''.

SEC. 15223. REVISIONS IN DETERMINATION OF AMOUNT OF PAYMENT FOR MEDICAL EDUCATION.

(a) INDIRECT MEDICAL EDUCATION.—

(1) IN GENERAL.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clauses:

''(v) In determining such adjustment with respect to a hospital for discharges occurring on or after October 1, 1995, and on or before September 30, 2002—

''(I) the total number of interns and residents counted by the Secretary may not exceed the number of interns and residents counted with respect to the hospital as of August 1, 1995, and

''(II) the number of interns and residents counted by the Secretary who are not primary care residents (as defined in subsection (h)(5)(H)) may not exceed the number of such residents counted with respect to the hospital as of such date.

''(vi) In calculating the number of full-time-equivalent interns and residents of a hospital in determining such adjustment with respect to the hospital, the Secretary shall provide for a weighting factor of .50 with respect to each intern and resident who is not in an initial residency period (as defined in subsection (h)(5)(F)).''.

(2) PAYMENT FOR INTERNS AND RESIDENTS PROVIDING OFF-SITE SERVICES.—Section 1886(d)(5)(B)(iv) (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended by striking ''any entity'' and all that follows through ''and residents)'' and inserting ''any other entity under an agreement with the hospital''.

(b) DIRECT MEDICAL EDUCATION.—

(1) LIMITATION ON NUMBER OF RESIDENTS.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1995, and on or before September 30, 2002—

''(i) the total number of full-time-equivalent residents determined under this paragraph with respect to an approved medical residency training program may not exceed the number of full-time-equivalent residents with respect to the program as of August 1, 1995, and

''(ii) the number of full-time-equivalent residents determined under this paragraph with respect to the program who are not primary care residents (as defined in paragraph (5)(H)) may not exceed the number of such residents counted with respect to the program as of such date.''.

(2) CONTINUATION OF FREEZE ON UPDATES TO FTE RESIDENT AMOUNTS.—Section 1886(h)(2)(D)(ii) (42 U.S.C. 1395ww(h)(2)(D)(ii)) is amended by striking ''fiscal year 1994 or fiscal year 1995'' and inserting ''fiscal years 1994, 1995, 1996, or 1997''.

(3) PERMITTING PAYMENT TO NON-HOSPITAL PROVIDERS.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(j) Beginning with cost reporting periods beginning on or after July 1, 1996, notwithstanding any other provision of this title, the Secretary may make payments (in such amounts and in such form as the Secretary considers appropriate) to entities other than hospitals for the direct costs of medical education, if such costs are incurred in the operation of an approved medical residency training program described in subsection (h).''.

(c) EXPANDING DEFINITION OF PRIMARY CARE RESIDENTS.—Section 1886(h)(5)(H) (42 U.S.C. 1395ww(h)(5)(H)) is amended by inserting ''obstetrics and gynecology,'' after ''geriatric medicine,''.

(d) EFFECTIVE DATE.—Except as provided otherwise in this section (or in the amendments made by this section), the amendments made by this section apply to hospital cost reporting periods beginning on or after October 1, 1995.

SEC. 15224. PAYMENTS FOR HOME HEALTH SERVICES.

(a) REDUCTIONS IN COST LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) by inserting ''and before October 1, 1996,'' after ''July 1, 1987'' in subclause (III),

(2) by striking the period at the end of the matter following subclause (III), and inserting '', and'',

(3) by adding at the end the following new subclause:

''(IV) October 1, 1996, 105 percent of the median of the labor-related and nonlabor per visit costs for free standing home health agencies.''.

(b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking ''July 1, 1996'' and inserting ''October 1, 1996''.

(c) ADDITIONS TO COST LIMITS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following new clauses:

''(iv) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1996, the Secretary shall provide for an interim system of limits. Payment shall be the lower of—

''(I) costs determined under the preceding provisions of this subparagraph, or

''(II) an agency-specific per beneficiary annual limit calculated from the agency's 12-month cost reporting period ending on or after January 1, 1994 and on or before December 31, 1994 based on reasonable costs (including non-routine medical supplies), updated by the home health market basket index. The per beneficiary limitation shall be multiplied by the agency's unduplicated census count of Medicare patients for the year subject to the limitation. The limitation shall represent total Medicare reasonable costs divided by the unduplicated census count of Medicare patients.

''(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1996, the following rules shall apply:

''(I) For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limit shall be equal to the mean of these limits (or the Secretary's best estimates thereof) applied to home health agencies as determined by the Secretary. Home health agencies that have altered their corporate structure or name may not be considered new providers for payment purposes.

''(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitation shall be pro-rated among agencies.

''(vi) Home health agencies whose cost or utilization experience is below 125 percent of the mean national or census region aggregate per beneficiary cost or utilization experience for 1994, or best estimates thereof, and whose year-end reasonable costs are below the agency-specific per beneficiary limit, shall receive payment equal to 50 percent of the difference between the agency's reasonable costs and its limit for fiscal years 1996, 1997, 1998, and 1999. Such payments may not exceed 5 percent of an agency's aggregate Medicare reasonable cost in a year.

''(vii) Effective January 1, 1997, or as soon as feasible, the Secretary shall modify the agency specific per beneficiary annual limit described in clause (iv) to provide for regional or national variations in utilization. For purposes of determining payment under clause (iv), the limit shall be calculated through a blend of 75 percent of the agency-specific cost or utilization experience in 1994 with 25 percent of the national or census region cost or utilization experience in 1994, or the Secretary's best estimates thereof.''.

(d) USE OF INTERIM FINAL REGULATIONS.—The Secretary shall implement the payment limits described in section 1861(v)(1)(L)(iv) of the Social Security Act by publishing in the Federal Register a notice of interim final payment limits by August 1, 1996 and allowing for a period of public comments thereon. Payments subject to these limits will be effective for cost reporting periods beginning on or after October 1, 1996, without the necessity for consideration of comments received, but the Secretary shall, by Federal Register notice, affirm or modify the limits after considering those comments.

(e) STUDIES.—The Secretary shall expand research on a prospective payment system for home health agencies that shall tie prospective payments to an episode of care, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs. The Secretary shall develop such a system for implementation in fiscal year 2000.

(f) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Title XVIII is amended by adding at the end the following new section:

''PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1893. (a) Notwithstanding section 1861(v), the Secretary shall, for cost reporting periods beginning on or after fiscal year 2000, provide for payments for home health services in accordance with a prospective payment system, which pays home health agencies on a per episode basis, established by the Secretary.

''(b) Such a system shall include the following:

''(1) Per episode rates under the system shall be 15 percent less than those that would otherwise occur under fiscal year 2000 Medicare expenditures for home health services.

''(2) All services covered and paid on a reasonable cost basis under the Medicare home health benefit as of the date of the enactment of the Medicare Enhancement Act of 1995, including medical supplies, shall be subject to the per episode amount. In defining an episode of care, the Secretary shall consider an appropriate length of time for an episode the use of services and the number of visits provided within an episode, potential changes in the mix of services provided within an episode and their cost, and a general system design that will provide for continued access to quality services. The per episode amount shall be based on the most current audited cost report data available to the Secretary.

''(c) The Secretary shall employ an appropriate case mix adjuster that explains a significant amount of the variation in cost.

''(d) The episode payment amount shall be adjusted annually by the home health market basket index. The labor portion of the episode amount shall be adjusted for geographic differences in labor-related costs based on the most current hospital wage index.

''(e) The Secretary may designate a payment provision for outliers, recognizing the need to adjust payments due to unusual variations in the type or amount of medically necessary care.

''(f) A home health agency shall be responsible for coordinating all care for a beneficiary. If a beneficiary elects to transfer to, or receive services from, another home health agency within an episode period, the episode payment shall be pro-rated between home health agencies.''.

(g) LIMITATION ON PART A COVERAGE.—

(1) IN GENERAL.—Section 1812(a)(3) (42 U.S.C. 1395d(a)(3)) is amended by striking the semicolon and inserting ''for up to 160 visits during any spell of illness;''.

(2) CONFORMING AMENDMENT.—Section 1812(b) (42 U.S.C. 1395d(b)) is amended—

(A) by striking ''or'' at the end of paragraph (2),

(B) by striking the period at the end of paragraph (3) and inserting ''; or'', and

(C) by adding at the end the following new paragraph:

''(4) home health services furnished to the individual during such spell after such services have been furnished to the individual for 160 visits during such spell.''.

(3) EXCLUSION OF ADDITIONAL PART B COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

(A) in the second sentence of paragraph (1), by striking ''enrollees.'' and inserting ''enrollees (except as provided in paragraph (5)).''; and

(B) by adding at the end the following new paragraph:

''(5) In estimating the benefits and administrative costs which will be payable from the Federal Supplementary Medical Insurance Trust Fund for a year (beginning with 1996), the Secretary shall exclude an estimate of any benefits and costs attributable to home health services for which payment would have been made under part A during the year but for paragraph (4) of section 1812(b).''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to spells of illness beginning on or after October 1, 1995.

(h) REQUIRING BILLING AND PAYMENT TO BE BASED ON SITE WHERE SERVICE FURNISHED.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following new subsection:

''(g) A home health agency shall submit claims for payment for home health services under this title only on the basis of the geographic location at which the service is furnished.''.

(i) MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES.—

(1) BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by adding at the end the following sentence: ''In establishing limits under this subparagraph, the Secretary may not take into account any changes in the costs of the provision of services furnished by home health agencies with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.''.

(2) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by paragraph (1) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act.

SEC. 15225. REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO COVER APPROPRIATE RANGE OF SERVICES.

(a) IN GENERAL.—Section 1876(c) (42 U.S.C. 1395mm(c)) is amended by adding at the end the following new paragraph:

''(9) The organization shall not deny any health care professionals, based solely on the license or certification as applicable under State law, the ability to participate in providing services covered under the contract under this section, or be reimbursed or indemnified or by a network plan for providing such services under the contract.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to risk-sharing contracts under section 1876 of the Social Security Act which entered into or renewed on or after January 1, 1996.

SEC. 15226. CLARIFICATION OF MEDICARE COVERAGE OF ITEMS AND SERVICES ASSOCIATED WITH CERTAIN MEDICAL DEVICES APPROVED FOR INVESTIGATIONAL USE.

(a) COVERAGE.—Nothing in title XVIII of the Social Security Act may be construed to prohibit coverage under part A or part B of the medicare program of items and services associated with the use of a medical device in the furnishing of inpatient or outpatient hospital services (including outpatient diagnostic imaging services) for which payment may be made under the program solely on the grounds that the device is not an approved device, if—

(1) the device is an investigational device; and

(2) the device is used instead of either an approved device or a covered procedure.

(b) CLARIFICATION OF PAYMENT AMOUNT.—Notwithstanding any other provision of title XVIII of the Social Security Act, the amount of payment made under the medicare program for any item or service associated with the use of an investigational device in the furnishing of inpatient or outpatient hospital services (including outpatient diagnostic imaging services) for which payment may be made under the program may not exceed the amount of the payment which would have been made under the program for the item or service if the item or service were associated with the use of an approved device or a covered procedure.

(c) DEFINITIONS.—In this section—

(1) the term ''approved device'' means a medical device (or devices) which has been approved for marketing under pre-market approval under the Federal Food, Drug, and Cosmetic Act or cleared for marketing under a 510(k) notice under such Act; and

(2) the term ''investigational device'' means—

(A) a medical device or devices (other than a device described in paragraph (1)) approved for investigational use under section 520(g) of the Federal Food, Drug, and Cosmetic Act, or

(B) an investigational combination product under section 503(g) of the Federal Food, Drug, and Cosmetic Act which includes a device (or devices) authorized for use under section 505(i) of such Act.

SEC. 15227. COMMISSION ON THE FUTURE OF MEDICARE AND THE PROTECTION OF THE HEALTH OF THE NATION'S SENIOR CITIZENS.

(a) ESTABLISHMENT.—There is established a commission to be known as the Commission on the Future of Medicare and the Protection of the Health of the Nation's Senior Citizens (in this section referred to as the ''Commission'').

(b) DUTIES.—

(1) IN GENERAL.—The Commission shall—

(A) analyze indicators of the health status of individuals in the United States who are eligible for benefits under the medicare program;

(B) make specific recommendations on actions which may be taken to improve the medicare program which would promote the health of medicare beneficiaries;

(C) analyze the effect of changes in the medicare program (including changes in medicare payments) on the access to and delivery of health care services to individuals who are not medicare beneficiaries;

(D) examine the financial impact on the medicare program of the significant increase in the number of medicare eligible individuals which will occur beginning approximately during 2010 and lasting for approximately 25 years, and

(E) make specific recommendations to the Congress respecting a comprehensive approach to preserve the medicare program for the period during which such individuals are eligible for medicare.

(2) CONSIDERATIONS IN MAKING RECOMMENDATIONS.—In making its recommendations, the Commission shall consider the following:

(A) The amount and sources of Federal funds to finance the medicare program.

(B) The most efficient and effective manner of administering the program.

(C) Methods used by other nations to finance the delivery of health care services to their citizens.

(D) The financial impact on the medicare program of increases in the number of individuals in the United States without health insurance coverage.

(c) MEMBERSHIP.—

(1) APPOINTMENT.—The Commission shall be composed of 15 members appointed as follows:

(A) The President shall appoint 3 members.

(B) The Majority Leader of the Senate shall appoint 3 members.

(C) The Minority Leader of the Senate shall appoint 3 members.

(D) The Speaker of the House of Representatives shall appoint 3 members.

(E) The Minority Leader of the House of Representatives shall appoint 3 members.

(2) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a Chairman and Vice Chairman from among its members.

(3) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(4) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(5) MEETINGS.—The Commission shall meet at the call of its Chairman or a majority of its members.

(6) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

(d) STAFF AND CONSULTANTS.—

(1) STAFF.—The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(2) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b)

of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

(e) POWERS.—

(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(2) STUDIES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(A) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) ACCEPTANCE OF DONATIONS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(10) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.

(f) REPORT.—Not later than May 1, 1997, the Commission shall submit to Congress a report containing its findings and recommendations regarding how to protect and preserve the medicare program in a financially solvent manner until 2030 (or, if later, throughout the period of projected solvency of the Federal Old-Age and Survivors Insurance Trust Fund). The report shall include detailed recommendations for appropriate legislative initiatives respecting how to accomplish this objective.

(g) TERMINATION.—The Commission shall terminate 60 days after the date of submission of the report required in subsection (f).

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,500,000 to carry out this section. Amounts appropriated to carry out this section shall remain available until expended.

Subtitle D—Preventing Fraud and Abuse

PART 1—AMENDMENTS TO ANTI-FRAUD AND ABUSE PROVISIONS APPLICABLE TO MEDICARE, MEDICAID, AND STATE HEALTH CARE PROGRAMS

SEC. 15301. ANTI-KICKBACK STATUTORY PROVISIONS.

(a) REVISION TO PENALTIES.—

(1) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking ''or'' at the end of paragraphs (1) and (2);

(B) by striking the semicolon at the end of paragraph (3) and inserting ''; or''; and

(C) by inserting after paragraph (3) the following new paragraph:

''(4) carries out any activity in violation of paragraph (1) or (2) of section 1128B(b);''.

(2) DESCRIPTION OF CIVIL MONETARY PENALTY APPLICABLE.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking ''given).'' at the end of the first sentence and inserting the following: ''given or, in cases under paragraph (4), $50,000 for each such violation).''; and

(B) by striking ''claim.'' at the end of the second sentence and inserting the following: ''claim (or, in cases under paragraph (4), damages of not more than three times the total amount of remuneration offered, paid, solicited, or received.''.

(3) INCREASE IN CRIMINAL PENALTY.—Paragraphs (1) and (2) of section 1128B(b) (42 U.S.C. 1320a–7b(b)) are each amended—

(A) by striking ''$25,000'' and inserting ''$50,000''; and

(B) by striking the period at the end and inserting the following: '', and shall be subject to damages of not more than three times the total remuneration offered, paid, solicited, or received.''.

(b) REVISIONS TO EXCEPTIONS.—

(1) EXCEPTION FOR DISCOUNTS.—Section 1128B(b)(3)(A) (42 U.S.C. 1320a–7b(b)(3)(A)) is amended by striking ''program;'' and inserting ''program and is not in the form of a cash payment;''.

(2) EXCEPTION FOR PAYMENTS TO EMPLOYEES.—Section 1128B(b)(3)(B) (42 U.S.C. 1320a–7b(b)(3)(B)) is amended by inserting at the end ''if the amount of remuneration under the arrangement is consistent with the fair market value of the services and is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals, except that such employee can be paid remuneration in the form of a productivity bonus based on services personally performed by the employee.''.

(3) EXCEPTION FOR WAIVER OF COINSURANCE BY CERTAIN PROVIDERS.—Section 1128B(b)(3)(D) (42 U.S.C. 1320a–7b(b)(3)(D)) is amended to read as follows:

''(D) a waiver or reduction of any coinsurance or other copayment if—

''(i) the waiver or reduction is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply to certain individuals,

''(ii) the waiver or reduction is made pursuant to an established program and applies to a defined group of individuals whose incomes do not exceed 150 percent (or such higher percentage as the Secretary may permit) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

''(iii) the waiver or reduction of coinsurance is not offered as part of any advertisement or solicitation and the person offering the waiver or reduction determines in good faith that the individual is in financial need,

''(iv) the person offering the waiver or reduction fails to collect the coinsurance or other payment after making reasonable collection efforts, or

''(v) the waiver or reduction of coinsurance is in accordance with a cost sharing schedule or a supplemental benefit package which may be offered by a managed care plan (as defined in section 1128(j)); and''.

(4) NEW EXCEPTION FOR CAPITATED PAYMENTS.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(A) by striking ''and'' at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

(C) by adding at the end the following new subparagraphs:

''(F) any reduction in cost sharing or increased benefits given to an individual, any amounts paid to a provider for an item or service furnished to an individual, or any discount or reduction in price given by the provider for such an item or service, if the individual is enrolled with and such item or service is covered under any of the following:

''(i) A health plan which is furnishing items or services under a risk-sharing contract under section 1876 or section 1903(m).

''(ii) A health plan receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972; and

''(G) any amounts paid to a provider for an item or service furnished to an individual or any discount or reduction in price given by the provider for such an item or service, if the individual is enrolled with and such item or service is covered under a health plan under which the provider furnishing the item or service is paid by the health plan for furnishing the item or service only on a capitated basis pursuant to a written arrangement between the plan and the provider in which the provider assumes financial risk for furnishing the item or service.''.

(c) AUTHORIZATION FOR THE SECRETARY TO ISSUE REGULATIONS.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

''(4) The Secretary is authorized to impose by regulation such other requirements as needed to protect against program or patient abuse with respect to any of the exceptions described in paragraph (3).''.

(d) CLARIFICATION OF OTHER ELEMENTS OF OFFENSE.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)) is amended—

(1) in paragraph (1)(A), by striking ''in return for referring'' and inserting ''to refer'';

(2) in paragraph (1)(B), by striking ''in return for purchasing, leasing, ordering, or arranging for or recommending'' and inserting ''to purchase, lease, order, or arrange for or recommend''; and

(3) by adding at the end of paragraphs (1) and (2) the following sentence: ''A violation exists under this paragraph if one or more purposes of the remuneration is unlawful under this paragraph.''.

SEC. 15302. CIVIL MONEY PENALTIES.

(a) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by section 15301(a)(1), is amended—

(A) by striking ''; or'' at the end of paragraph (3) and inserting a semicolon;

(B) by striking the semicolon at the end of paragraph (4) and inserting ''; or''; and

(C) by inserting after paragraph (4) the following new paragraph:

''(5) offers, pays, or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program, other than to influence an individual enrolled in a managed care plan or a point-of-service plan (as defined in section 1128(j)) to receive benefits under the plan in accordance with established practice patterns for the delivery of medically necessary services;''.

(2) REMUNERATION DEFINED.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

''(6) The term 'remuneration' includes the waiver or reduction of coinsurance amounts, and transfers of items or services for free or for other than fair market value, except that such term does not include the waiver or reduction of coinsurance amounts by a person or entity, if—

''(A) the waiver or reduction is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply to certain individuals,

''(B) the waiver or reduction is made pursuant to an established program and applies to a defined group of individuals whose incomes do not exceed 150 percent (or such higher percentage as the Secretary may permit) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

''(C) the waiver or reduction of coinsurance is not offered as part of any advertisement or solicitation and the person offering the waiver or reduction determines in good faith that the individual is in financial need,

''(D) the person offering the waiver or reduction fails to collect the coinsurance or other payment after making reasonable collection efforts, or

''(E) the waiver or reduction of coinsurance is in accordance with a cost sharing schedule or a supplemental benefit package which may be offered by a managed care plan under section 1128(j).''.

(b) ADDITIONAL OFFENSES.—Section 1128A(a) of such Act, as amended by section 15301(a)(1) and subsection (a)(1), is further amended—

(1) by striking ''or'' at the end of paragraph (4);

(2) by striking the semicolon at the end of paragraph (5) and inserting ''; or''; and

(3) by inserting after paragraph (5) the following new paragraphs:

''(6) engages in a practice which has the effect of limiting or discouraging (as compared to other plan enrollees) the utilization of medically necessary health care services covered by law or under the service contract by title XIX or other publicly subsidized patients, including but not limited to differential standards for the location and hours of service offered by providers participating in the plan;

''(7) substantially fails to cooperate with a quality assurance program or a utilization review activity; or

''(8) engaging in a pattern of failing substantially to provide or authorize medically necessary items and services that are required to be provided to an individual covered under a health plan (as defined in section 1128(j)) or public program for the delivery of or payment for health care items or services, if the failure has adversely affected (or had a substantial likelihood of adversely affecting) the individual;''.

''(9) submits false or fraudulent statements, data or information on claims to the Secretary, a State health care agency, or any other Federal, State or local agency charged with implementation or oversight of a health plan or a public program that the person knows or should know is fraudulent;''.

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by section 15301(a), subsection (a)(1), and subsection (b), is amended in the matter following paragraph (9)—

(1) by striking ''$2,000'' and inserting ''$10,000'';

(2) by inserting after ''under paragraph (4), $50,000 for each such violation'' the following: ''; in cases under paragraph (5), $10,000 for each such offer, payment, or transfer; in cases under paragraphs (6) through (9), an amount not to exceed $10,000 for each such determination by the Secretary''; and

(3) by striking ''twice the amount'' and inserting ''three times the amount''.

(d) INTEREST ON PENALTIES.—Section 1128A(f) (42 U.S.C. 1320a–7a(f)) is amended by adding after the first sentence the following: ''Interest shall accrue on the penalties and assessments imposed by a final determination of the Secretary in accordance with an annual rate established by the Secretary under the Federal Claims Collection Act. The rate of interest charged shall be the rate in effect on the date the determination becomes final and shall remain fixed at that rate until the entire amount due is paid. In addition, the Secretary is authorized to recover the costs of collection in any case where the penalties and assessments are not paid within 30 days after the determination becomes final, or in the case of a compromised amount, where payments are more than 90 days past due. In lieu of actual costs, the Secretary is authorized to impose a charge of up to 10 percent of the amount of penalties and assessments owed to cover the costs of collection.''.

(e) AUTHORIZATION TO ACT.—

(1) IN GENERAL.—The first sentence of section 1128A(c)(1) (42 U.S.C. 1320a–7a(c)(1)) is amended by striking all that follows ''(b)'' and inserting the following: ''unless, within one year after the date the Secretary presents a case to the Attorney General for consideration, the Attorney General brings an action in a district court of the United States.''.

(2) EFFECTIVE DATE.—The amendment made by this paragraph (1) shall apply to cases presented by the Secretary of Health and Human Services for consideration on or after the date of the enactment of this Act.

(f) CLARIFICATION OF PENALTY IMPOSED ON EXCLUDED PROVIDER FURNISHING SERVICES.—Section 1128A(a)(1)(D) (42 U.S.C. 1320a–7a(a)(1)(D)) is amended by inserting ''who furnished the service'' after ''in which the person''.

SEC. 15303. PRIVATE RIGHT OF ACTION.

Section 1128A (42 U.S.C. 1320a–7a) is amended by adding at the end the following new subsection:

''(m)(1) Subject to paragraphs (2) and (3), a carrier offering an insured health plan and the sponsor of a self-insured health plan that suffers financial harm as a direct result of the submission of claims by an individual or entity for payment for items and services furnished under the plan which makes the individual or entity subject to a civil monetary penalty under this section may, in a civil action against the individual or entity in the United States District Court, obtain damages against the individual or entity and such equitable relief as is appropriate.

''(2) A carrier or sponsor may bring a civil action under this subsection only if the carrier or sponsor provides the Secretary and the Attorney General with written notice of the intent to bring an action under this subsection, the identities of the individuals or entities the carrier or sponsor intends to name as defendants to the action, and all information the carrier or sponsor possesses regarding the activity that is the subject of the action that may materially affect the Secretary's decision to initiate a proceeding to impose a civil monetary penalty under this section against the defendants.

''(3) A carrier or sponsor may bring a civil action under this subsection only if any of the following conditions are met:

''(A) During the 60-day period that begins on the date the Secretary receives the written notice described in paragraph (2), the Secretary does not notify the carrier or sponsor that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this section against the defendants.

''(B) If the Secretary notifies the carrier or sponsor during the 60-day period described in subparagraph (A) that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this section against the defendants, the Secretary subsequently notifies the carrier or sponsor that the Secretary no longer intends to initiate such a proceeding against the defendants.

''(C) After the expiration of the 2-year period that begins on the date the Secretary notifies the carrier or sponsor that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this section against the defendants, the Secretary has not made a good faith effort to initiate such a proceeding against the defendants.

''(4) No action may be brought under this subsection more than 6 years after the date of the activity with respect to which the action is brought.''.

SEC. 15304. AMENDMENTS TO EXCLUSIONARY PROVISIONS IN FRAUD AND ABUSE PROGRAM.

(a) MANDATORY EXCLUSION OF INDIVIDUAL CONVICTED OF CRIMINAL OFFENSE RELATED TO HEALTH CARE FRAUD.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

''(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted under Federal or State law, in connection with the delivery of a health care item or service on or after January 1, 1997, or with respect to any act or omission on or after such date in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(1) (42 U.S.C. 1320a–7(b)(1)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

(b) ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.—

(1) IN GENERAL.—Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraphs (1), (2), or (3) of subsection (b), the period of exclusion shall be a minimum of 3 years, unless the Secretary determines that an alternative period is appropriate because of aggravating or mitigating circumstances.

''(E) In the case of an exclusion of an individual or entity under paragraph (4) or (5) of subsection (b), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

(2) CONFORMING AMENDMENT.—Section 1128(c)(3)(A) (42 U.S.C. 1320a–7(c)(3)(A)) is amended by striking ''subsection (b)(12)'' and inserting ''paragraph (1), (2), (3), (4), (6)(B), or (12) of subsection (b)''.

SEC. 15305. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS RELATING TO QUALITY OF CARE.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended by striking ''may prescribe)'' and inserting ''may prescribe, except that such period may not be less than one year)''.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) (42 U.S.C. 1320c-5(b)(2)) is amended by striking ''shall remain'' and inserting ''shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain''.

(b) AMOUNT OF CIVIL MONEY PENALTY.—Section 1156(b)(3) (42 U.S.C. 1320c-5(b)(3)) is amended by striking ''the actual or estimated cost'' and inserting the following: ''$10,000 for each instance''.

(c) REPEAL OF ''UNWILLING OR UNABLE'' CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended—

(1) in the second sentence, by striking ''and determines'' and all that follows through ''such obligations,'' and

(2) by striking the third sentence.

SEC. 15306. REVISIONS TO CRIMINAL PENALTIES.

(a) TREBLE DAMAGES FOR CRIMINAL SANCTIONS.—Section 1128B (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

''(f) In addition to the fines that may be imposed under subsection (a) or (c) any individual found to have violated the provisions of any of such subsections may be subject to treble damages.''.

(b) IDENTIFICATION OF COMMUNITY SERVICE OPPORTUNITIES.—Section 1128B (42 U.S.C. 1320a–7b), as amended by subsection (a), is further amended by adding at the end the following new subsection:

''(g) The Secretary shall—

''(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

''(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.''.

SEC. 15307. DEFINITIONS.

Section 1128 (42 U.S.C. 1320a–7) is amended by adding at the end the following new subsection:

''(j) OTHER DEFINITIONS RELATING TO HEALTH PLANS.—

''(1) HEALTH PLAN.—The term 'health plan' means—

''(A) any contract of health insurance, including any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract, that is provided by a carrier in a State; or

''(B) an employee welfare benefit plan or other arrangement insofar as the plan or arrangement provides health benefits in a State and is funded in a manner other than through the purchase of one or more policies or contracts described in subparagraph (A).

''(2) MANAGED CARE PLAN.—The term 'managed care plan' means a health plan that provides for items and services covered under the plan primarily through providers in the provider network of the plan.

''(3) POINT-OF-SERVICE PLAN.—The term 'point-of-service plan' means a health plan other than a managed care plan that permits an enrollee to receive benefits through a provider network.

''(4) PROVIDER NETWORK.—The term 'provider network' means, with respect to a health plan, providers who have entered into an agreement with the plan under which such providers are obligated to provide items and services covered under the plan to individuals enrolled in the plan.''.

SEC. 15308. EFFECTIVE DATE.

The amendments made by this part shall take effect January 1, 1997.

PART 2—INTERPRETIVE RULINGS ON KICKBACKS AND SELF-REFERRAL

SEC. 15311. ESTABLISHMENT OF PROCESS FOR ISSUANCE OF INTERPRETIVE RULINGS.

(a) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (acting through the Inspector General of the Department of Health and Human Services) shall establish a process under which individuals and entities may submit a request to the Secretary for an interpretive ruling regarding the provisions of section 1128B(b) of the Social Security Act or part 3 which relate to kickbacks, bribes, and rebates, or the provisions of section 1877 of the Social Security Act.

(b) DEADLINE FOR REJECTION OF REQUEST.—If the Secretary of Health and Human Services rejects a request for an interpretive ruling submitted under this section, the Secretary shall notify the individual submitting the request of the rejection not later than 60 days after receiving the request.

SEC. 15312. EFFECT OF ISSUANCE OF INTERPRETIVE RULING.

(a) NO LEGAL EFFECT.—If the Secretary of Health and Human Services issues an interpretive ruling under section 15311, the ruling shall not be binding upon the Secretary, the party requesting the ruling, or any other party.

(b) PUBLICATION OF RULINGS.—The Secretary of Health and Human Services shall publish each interpretive ruling issued under section 15311 in the Federal Register.

SEC. 15313. IMPOSITION OF FEES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall require an individual or entity requesting an interpretive ruling under section 15311 to submit a fee.

(b) AMOUNT.—The amount of the fee required under subsection (a) shall be equal to the costs incurred by the Secretary in responding to the request.

PART 3—DIRECT SPENDING FOR ANTI-FRAUD ACTIVITIES UNDER MEDICARE

SEC. 15321. DIRECT SPENDING FOR ANTI-FRAUD ACTIVITIES UNDER MEDICARE.

Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 15224(f), is amended by adding at the end the following new section:

''APPROPRIATIONS FOR COMBATING FRAUD AND ABUSE

''SEC. 1894. (a) DIRECT SPENDING FOR PAYMENT SAFEGUARD ACTIVITIES.—

''(1) IN GENERAL.—There are appropriated from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund for each fiscal year such amounts as are necessary to carry out the payment safeguard activities described in paragraph (2), subject to paragraph (3).

''(2) ACTIVITIES DESCRIBED.—The payment safeguard activities described in this paragraph are as follows:

''(A) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review.

''(B) Audit of cost reports.

''(C) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

''(D) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

''(3) AMOUNTS SPECIFIED.—The amount appropriated under paragraph (1) for a fiscal year is as follows:

''(A) For fiscal year 1996, such amount shall be not less than $430,000,000 and not more than $440,000,000.

''(B) For fiscal year 1997, such amount shall be not less than $490,000,000 and not more than $500,000,000.

''(C) For fiscal year 1998, such amount shall be not less than $550,000,000 and not more than $560,000,000.

''(D) For fiscal year 1999, such amount shall be not less than $620,000,000 and not more than $630,000,000.

''(E) For fiscal year 2000, such amount shall be not less than $670,000,000 and not more than $680,000,000.

''(F) For fiscal year 2001, such amount shall be not less than $690,000,000 and not more than $700,000,000.

''(G) For fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

''(b) DIRECT SPENDING FOR MEDICARE-RELATED ACTIVITIES OF INSPECTOR GENERAL.—

''(1) IN GENERAL.—There are appropriated from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Inspector General of the Department of Health and Human Services for each fiscal year such amounts as are necessary to enable the Inspector General to carry out activities relating to the medicare program (as described in paragraph (2)), subject to paragraph (3).

''(2) ACTIVITIES DESCRIBED.—The activities described in this paragraph are as follows:

''(A) Prosecuting medicare-related matters through criminal, civil, and administrative proceedings.

''(B) Conducting investigations relating to the medicare program.

''(C) Performing financial and performance audits of programs and operations relating to the medicare program.

''(D) Performing inspections and other evaluations relating to the medicare program.

''(E) Conducting provider and consumer education activities regarding the requirements of this title.

''(3) AMOUNTS SPECIFIED.—The amount appropriated under paragraph (1) for a fiscal year is as follows:

''(A) For fiscal year 1996, such amount shall be $130,000,000.

''(B) For fiscal year 1997, such amount shall be $181,000,000.

''(C) For fiscal year 1998, such amount shall be $204,000,000.

''(D) For each subsequent fiscal year, the amount appropriated for the previous fiscal year, increased by the percentage increase in aggregate expenditures under this title for the fiscal year involved over the previous fiscal year.

''(c) ALLOCATION OF PAYMENTS AMONG TRUST FUNDS.—The appropriations made under subsection (a) and subsection (b) shall be in an allocation as reasonably reflects the proportion of such expenditures associated with part A and part B.''.

PART 4—PREEMPTION OF STATE CORPORATE PRACTICE LAWS UNDER MEDICARE

SEC. 15331. PREEMPTION OF STATE LAWS PROHIBITING CORPORATE PRACTICE OF MEDICINE FOR PURPOSES OF MEDICARE.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''PERMITTING CORPORATIONS TO SERVE AS PROVIDERS

''SEC. 1893. The Secretary may not refuse to treat any individual or entity as a provider of services under this title or refuse to make payment under this title to the individual or entity on the grounds that the individual or entity is prohibited from practicing medicine under a provision of State or local law which prohibits a corporation from practicing medicine.''.

PART 5—MEDICARE ANTI-FRAUD AND ABUSE COMMISSION

SEC. 15341. ESTABLISHMENT OF MEDICARE ANTI-FRAUD AND ABUSE COMMISSION

(a) IN GENERAL.—There is established a commission to be known as the ''Medicare Anti-Fraud and Abuse Commission'' (in this title referred to as the ''Commission'').

(b) COMPOSITION.—The Commission shall be composed of 8 members as follows:

(1) OFFICIALS.—

(A) The Secretary of Health and Human Services (or the Secretary's designee).

(B) The Inspector General of the Department of Health and Human Services (or the Inspector General's designee).

(C) The Administrator of the Health Care Financing Administration (or the Administrator's designee).

(2) PUBLIC MEMBERS.—Five members, appointed by the President, of which—

(A) one shall be a representative of physicians;

(B) one shall be a representative of hospital administrators;

(C) one shall be a representative of medicare carriers;

(D) one shall be a representative of medicare peer review organizations; and

(E) one shall be a representative of medicare beneficiaries.

In making appointments under this paragraph of an individual who is a representative of persons or organizations, the President shall consider the recommendations of national organizations that represent such persons or organizations. The President shall report to Congress, within 90 days after the date of the enactment of this Act, the names of the members appointed under this paragraph.

(c) TERMS.—Each member shall be appointed for the life of the Commission. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

SEC. 15342. FUNCTIONS OF COMMISSION.

(a) IN GENERAL.—The Commission shall—

(1) investigate the nature, magnitude, and cost of health care fraud and abuse in the medicare program, and

(2) identify and develop the most effective methods of preventing, detecting, and prosecuting or litigating such fraud and abuse, with particular emphasis on coordinating public and private prevention, detection, and enforcement efforts.

(b) PARTICULARS.—Among other items, the Commission shall examine at least the following:

(1) Mechanisms to provide greater standardization of claims administration in order to accommodate fraud prevention and detection.

(2) Mechanisms to allow more freedom of the medicare program to exchange information for coordinating case development and prosecution or litigation efforts, without undermining patient and provider privacy protections or violating anti-trust laws.

(3) Criteria for physician referrals to facilities in which they (or family members) have a financial interest.

(4) The availability of resources to the medicare program to combat fraud and abuse.

(c) REPORT.—After approval by a majority vote, a quorum being present, the Commission shall transmit to Congress a report on its activities. The report shall be transmitted not later than 18 months after the date that a majority of the public members of the Commission have been appointed. The report shall contain a detailed statement of the Commission's findings, together with such recommendations as the Commission considers appropriate.

SEC. 15343. ORGANIZATION AND COMPENSATION.

(a) ORGANIZATION.—

(1) QUORUM.—A majority of the members of the Commission shall constitute a quorum but a lesser number may hold hearings.

(2) CHAIRMAN.—The Commission shall elect one of its members to serve as chairman of the Commission.

(3) MEETINGS.—The Commission shall meet at the call of the chairman or a majority of its members. Meetings of the Commission are open to the public under section 10(a)(10) of the Federal Advisory Committee Act, except that the Commission may conduct meetings in executive session but only if a majority of the members of the Commission (a quorum being present) approve going into executive session.

(b) COMPENSATION OF MEMBERS.—Members of the Commission shall serve without compensation, but shall be reimbursed for travel, subsistence, and other necessary expenses incurred in the performance of their duties as members of the Commission.

SEC. 15344. STAFF OF COMMISSION.

(a) IN GENERAL.—The Commission may appoint and fix the compensation of a staff director and such other additional personnel as may be necessary to enable the Commission to carry out its functions, without regard to the laws, rules, and regulations governing appointment and compensation and other conditions of service in the competitive service.

(b) DETAIL OF FEDERAL EMPLOYEES.—Upon request of the chairman, any Federal employee who is subject to such laws, rules, and regulations, may be detailed to the Commission to assist it in carrying out its functions under this title, and such detail shall be without interruption or loss of civil service status or privilege.

(c) EXPERTS AND CONSULTANTS.—The Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, but at rates for individuals not to exceed the daily equivalent of 120 percent of the maximum annual rate of basic pay payable for GS–15 of the General Schedule.

SEC. 15345. AUTHORITY OF COMMISSION.

(a) HEARINGS AND SESSIONS.—The Commission may, for the purpose of carrying out this title, hold hearings, sit and act at times and places, take testimony, and receive evidence as the Commission considers appropriate. The Commission may administer oaths or affirmations to witnesses appearing before it.

(b) OBTAINING OFFICIAL DATA.—

(1) IN GENERAL.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this title. Upon request of the chairman of the Commission, the head of that department or agency shall furnish that information to the Commission.

(2) ACCESS TO INFORMATION.—Information obtained by the Commission is available to the public in the same manner in which information may be made available under sections 552 and 552a of title 5, United States Code.

(c) GIFTS, BEQUESTS, AND DEVISES.—The Commission may accept, use, and dispose of gifts, bequests, or devises of services or property for the purpose of aiding or facilitating the work of the Commission.

(d) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

(e) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this title.

(f) SUBPOENA POWER.—

(1) IN GENERAL.—The Commission may issue subpoenas requiring the attendance and testimony of witnesses and the production of any evidence relating to any matter which the Commission is authorized to investigate under this title. The attendance of witnesses and the production of evidence may be required from any place within the United States at any designated place of hearing within the United States.

(2) FAILURE TO OBEY A SUBPOENA.—If a person refuses to obey a subpoena issued under paragraph (1), the Commission may apply to a United States district court for an order requiring that person to appear before the Commission to give testimony, produce evidence, or both, relating to the matter under investigation. The application may be made within the judicial district where the hearing is conducted or where that person is found, resides, or transacts business. Any failure to obey the order of the court may be punished by the court as civil contempt.

(3) SERVICE OF SUBPOENAS.—The subpoenas of the Commission shall be served in the manner provided for subpoenas issued by a United States district court under the Federal Rules of Civil Procedure for the United States district courts.

(4) SERVICE OF PROCESS.—All process of any court to which application is to be made under paragraph (2) may be served in the judicial district in which the person required to be served resides or may be found.

SEC. 15346. TERMINATION.

The Commission shall terminate 90 days after the date the report is submitted under section 15342(c).

SEC. 15347. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to the Commission such sums as are necessary to carry out its functions, to remain available until expended.

H.R. 2425

OFFERED BY: MR. RANGEL

(Amendment in the Nature of a Substitute)

AMENDMENT NO. 3: Strike all after the enacting clause and insert the following:

TITLE XV—MEDICARE

SEC. 15001. COMMISSION ON THE FUTURE OF MEDICARE AND THE PROTECTION OF THE HEALTH OF THE NATION'S SENIOR CITIZENS.

(a) ESTABLISHMENT.—There is established a commission to be known as the Commission on the Future of Medicare and the Protection of the Health of the Nation's Senior Citizens (in this section referred to as the ''Commission'').

(b) DUTIES.—

(1) IN GENERAL.—The Commission shall—

(A) analyze indicators of the health status of individuals in the United States who are eligible for benefits under the medicare program;

(B) make specific recommendations on actions which may be taken to improve the medicare program which would promote the health of medicare beneficiaries;

(C) analyze the effect of changes in the medicare program (including changes in medicare payments) on the access to and delivery of health care services to individuals who are not medicare beneficiaries;

(D) examine the financial impact on the medicare program of the significant increase in the number of medicare eligible individuals which will occur beginning approximately during 2010 and lasting for approximately 25 years, and

(E) make specific recommendations to the Congress respecting a comprehensive approach to preserve the medicare program for the period during which such individuals are eligible for medicare.

(2) CONSIDERATIONS IN MAKING RECOMMENDATIONS.—In making its recommendations, the Commission shall consider the following:

(A) The amount and sources of Federal funds to finance the medicare program.

(B) The most efficient and effective manner of administering the program.

(C) Methods used by other nations to finance the delivery of health care services to their citizens.

(D) The financial impact on the medicare program of increases in the number of individuals in the United States without health insurance coverage.

(c) MEMBERSHIP.—

(1) APPOINTMENT.—The Commission shall be composed of 15 members appointed as follows:

(A) The President shall appoint 3 members.

(B) The Majority Leader of the Senate shall appoint 3 members.

(C) The Minority Leader of the Senate shall appoint 3 members.

(D) The Speaker of the House of Representatives shall appoint 3 members.

(E) The Minority Leader of the House of Representatives shall appoint 3 members.

(2) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a Chairman and Vice Chairman from among its members.

(3) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(4) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(5) MEETINGS.—The Commission shall meet at the call of its Chairman or a majority of its members.

(6) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

(d) STAFF AND CONSULTANTS.—

(1) STAFF.—The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(2) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

(e) POWERS.—

(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(2) STUDUES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(A) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) ACCEPTANCE OF DONATIONS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(10) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.

(f) REPORT.—Not later than May 1, 1997, the Commission shall submit to Congress a report containing its findings and recommendations regarding how to protect and preserve the medicare program in a financially solvent manner until 2030 (or, if later, throughout the period of projected solvency of the Federal Old-Age and Survivors Insurance Trust Fund). The report shall include detailed recommendations for appropriate legislative initiatives respecting how to accomplish this objective.

(g) TERMINATION.—The Commission shall terminate 60 days after the date of submission of the report required in subsection (f).

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,500,000 to carry out this section. Amounts appropriated to carry out this section shall remain available until expended.

SEC. 15002. LIMITATION ON TAX BENEFITS; APPROPRIATION OF SAVINGS TO MEDICARE PART A TRUST FUND.

(a) IN GENERAL.—Notwithstanding any other provision of law—

(1) the reduction in a taxpayer's net tax liability for any taxable period or event by reason of a provision referred to in subsection (c) shall not exceed the applicable fraction of the amount of such reduction (determined without regard to this section), and

(2) any increase in such liability for any taxable period or event by reason of such a provision shall not exceed the applicable fraction of such increase (determined without regard to this section).

(b) APPLICABLE FRACTION.—For purposes of subsection (a), the term ''applicable fraction'' means $^{155}/_{245}$.

(c) PROVISIONS.—The provisions referred to in this subsection are any provision of this Act or of any Act hereafter enacted which is the same as or comparable to any provision contained in subtitle A, B, C, or D of title VI of H.R. 1215 of the 104th Congress, as passed by the House of Representatives.

(d) NET TAX LIABILITY.—For purposes of subsection (a), the term ''net tax liability'' means the liability for tax under the Internal Revenue Code of 1986 determined—

(1) after the application of any credit against such tax other than the credits under sections 31, 33, and 34, and

(2) in the case of tax imposed by chapter 1 of such Code, before crediting any payment of estimated tax.

(e) APPROPRIATION OF SAVINGS TO MEDICARE PART A TRUST FUND.—There are hereby appropriated to the Federal Hospital Insurance Trust Fund established pursuant to section 1817 of the Social Security Act amounts equal to the aggregate increase in tax liabilities under chapter 1 of the Internal Revenue Code of 1986 which is attributable to the application of subsection (a). Such appropriated amounts shall be transferred from the general fund of the Treasury on the basis of estimates of such tax liabilities made by the Secretary of the Treasury. Transfers shall be made pursuant to a schedule made by the Secretary of the Treasury that takes into account estimated timing of collection of such liabilities.